

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

5065

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

302 05014

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 4 Weeks d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 535 West Church St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ELLEN Last ALDER		4. DATE OF DEATH Month April Day 8 Year 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9 1893
9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.	IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Michael Kreps	
14. MOTHER'S MAIDEN NAME Rosella Davis		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. ----		17. INFORMANT James R. Alder 435 No Colonial Dr	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Coronary Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) 4 1/2 yrs		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4-24 19 60 that (I) last saw the deceased alive 4-8 19 60 , and that death occurred 7:45 AM from the causes and on the date stated above.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-24 19 60 to 4-8 19 60 that (I) last saw the deceased alive 4-8 19 60 , and that death occurred 7:45 AM from the causes and on the date stated above.			
22a. SIGNATURE Dalton M. Welty		22b. DATE SIGNED 4-9-60	
22c. PHYSICIAN'S NAME (Type) DALTON M. WELTY		22d. ADDRESS 998 Potomac Ave, Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4/11/60	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25. REC'D BY REGISTRAR APR 12 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kane	

CERTIFICATE OF DEATH

2061

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5066

Item 8 Film 6201

CERTIFICATE OF DEATH

4/15/60 iwk

05015

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b 32 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17 South Foundry Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Kearfott Baker Ardinger		4. DATE OF DEATH Month Day Year April 9 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 28 1888
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 11 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator		10b. KIND OF BUSINESS OR INDUSTRY Painter	
11. BIRTHPLACE (State or foreign country) Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles Andrew Ardinger		14. MOTHER'S MAIDEN NAME Eliza Virginia Lemen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-9010	
17. INFORMANT Mrs. Florence Ardinger		17. ADDRESS 17 S. Foundry St. Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema - lungs (c) Asbestosis Bronchial			
INTERVAL BETWEEN ONSET AND DEATH Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 1958 to April 9, 1960 , that (I) (we) last saw the deceased alive on April 23, 1960 , and that death occurred at 6:15 M, from the causes and on the date stated above.			
22a. SIGNATURE Philip J. Hirshman		22b. DATE SIGNED 4/9/60	
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		22d. ADDRESS 159 W. Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 12-60	
23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION (City, town, or county) (State) Williamsport Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Alberta Desf Williamsport, Md		25a. REC'D BY REGISTRAR DATE APR 12 '60	
25b. REGISTRAR'S SIGNATURE William S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
M
X
I
0

5037

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05016
302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 3 c. LENGTH OF STAY IN 1b 55 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Alternate R # 40				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 3 d. STREET ADDRESS Alternate R # 40 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE BREWER ARTZ		4. DATE OF DEATH Month Day Year April 6 1960 19					
5. SEX Female	6. COLOR OR RACE white	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jany 8 1905	9. AGE (In years lost birthday) 55 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md USA			
13. FATHER'S NAME Frank M. Brewer			14. MOTHER'S MAIDEN NAME Minnie O. Stouffer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Howard M. Artz Hagerstown Md. R # 3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Obesity DUE TO (c) Hypertensive Vascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Alternate R # 40 INTERVAL BETWEEN ONSET AND DEATH 10 yrs 5 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 11-10-1959 to 4-6-1960 , that (I) (we) last saw the deceased alive on 2-1-1960 , and that death occurred at 4:14 AM , from the causes and on the date stated above.							
22a. SIGNATURE A. J. De Otto Jr		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Andrew K. Coffman		22d. ADDRESS Hagerstown Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4/9/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			
23d. LOCATION (City, town, or county)		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR APR 11 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Kline							

STATE OF TEXAS
COUNTY OF DALLAS

50-7

1

Know all men by these presents, that the undersigned, John A. Brown, of the County of Dallas, State of Texas, for and in consideration of the sum of Five Dollars, to John A. Brown, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said John A. Brown, his heirs and assigns forever, all that certain Tract of land, situate in the County of Dallas, State of Texas, containing Five Acres, more or less, the boundaries of which are as follows, to-wit:

Beginning at the Southwest Corner of the Tract of land, situate in the County of Dallas, State of Texas, containing Five Acres, more or less, the boundaries of which are as follows, to-wit:

Beginning at the Southwest Corner of the Tract of land, situate in the County of Dallas, State of Texas, containing Five Acres, more or less, the boundaries of which are as follows, to-wit:

Beginning at the Southwest Corner of the Tract of land, situate in the County of Dallas, State of Texas, containing Five Acres, more or less, the boundaries of which are as follows, to-wit:

Beginning at the Southwest Corner of the Tract of land, situate in the County of Dallas, State of Texas, containing Five Acres, more or less, the boundaries of which are as follows, to-wit:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5032

65017
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHARPSBURG</u>		c. LENGTH OF STAY IN 1b <u>03</u> <u>HAGERSTOWN MD.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ALONG ROUTE 34</u>			d. STREET ADDRESS <u>650 NORTH PROSPECT ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>CHARLES WILLIAM AUTHERS JR.</u>			4. DATE OF DEATH Month <u>APRIL</u> - Day <u>17</u> Year <u>1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 11 - 1935</u>	9. AGE (In years last birthday) <u>24</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRAFTSMAN - JANISON COLO STORAGE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. CO. MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
13. FATHER'S NAME <u>CHARLES WILLIAM AUTHERS SR</u>			14. MOTHER'S MAIDEN NAME <u>GOLDIE PALMER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-34-055</u>		17. INFORMANT <u>MRS. PATSY AUTHERS</u> Address <u>650 N. PROSPECT ST HAGERSTOWN MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Compound Comminuted Fracture Lt. Femur & Tibia</u> DUE TO (c) <u>Compound Fracture Of Left Humerus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Speeding car left road crashing into tree.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>9:17</u> p. m. <u>4-17-1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State R # 34</u>	
				20f. (City or town) (County) (State) <u>Sharpsburg, Wash. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-19-60</u>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR 21 - 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>	
				22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Dark</u>		ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 22 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knease</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05019

5067

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 40 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 25 WEST SIDE AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAUL Middle HARRY Last BARNHART		4. DATE OF DEATH Month APRIL Day 5 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/1897
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY LUMBER CO.	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY BARNHART		14. MOTHER'S MAIDEN NAME ADA HESSER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, if so, unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-1111	
17. INFORMANT MRS. AUDREY BARNHART		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymph sarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Jan , 19 57 , to 5 April , 19 60 , that I last saw the deceased alive on 4 April , 19 60 , and that death occurred at 225 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. John D. Howland M.D.		ADDRESS (Street, city or town, state) 115 W. Wash St DATE SIGNED 4/2/60	
PHYSICIAN'S NAME (Type) E. John G. Howland		Hagerstown Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/8/60	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman		24a. REC'D BY REGISTRAR DATE APR 11 '60	
ADDRESS Hagerstown, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

400

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH OF SPOUSE

NAME OF CHILD

DATE OF BIRTH OF CHILD

NAME OF CHILD

DATE OF BIRTH OF CHILD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

5099

05020

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Sharpsburg, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Waynesboro 75x3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Near Sharpsburg, Md.</u>		d. STREET ADDRESS <u>Route 3 - Waynesboro</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Lewis</u> Middle <u>Bingaman, Jr.</u> Last		4. DATE OF DEATH <u>4/17</u> Month <u>4</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>12/30/1930</u>	9. AGE (In years last birthday) <u>29</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	11. BIRTHPLACE (State or foreign country) <u>Waynesboro, Pa.</u>
13. FATHER'S NAME <u>John L. Bingaman</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Rowe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes 8/24/52 - 8/5/54</u>		16. SOCIAL SECURITY NO. <u>186-24-7587</u>	
17. INFORMANT <u>John L. Bingaman</u> Address <u>Waynesboro</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO <u>Fracture Cervical Vertebrae</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Compound Fracture Both Femur</u> DUE TO (c) <u>Entire face Crushed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Speeding car left road crashing into tree.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:41</u> p. m. <u>4-17</u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State R# 34 Sharpsburg Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. E. Mennich</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4/19/60</u>	
EXAMINER'S NAME (Type) <u>A. E. Mennich</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4/20/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Broadfording Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Wash. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Mennich</u> ADDRESS <u>Greencastle Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hantz</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		SEX Male	
AGE 35		DATE OF BIRTH 11-10-34	
PLACE OF BIRTH MOBILE, ALA.		OCCUPATION None	
MARITAL STATUS Single		COLOR White	
EDUCATION High School		RELIGION None	
PRESENT ADDRESS 1010 N. E. 10th St., Mobile, Ala.		DATE OF DEATH 4-4-68	
TIME OF DEATH 11:00 AM		PLACE OF DEATH Mobile, Ala.	
CAUSE OF DEATH Gunshot wound to the chest		MANNER OF DEATH Homicide	
MEDICAL HISTORY None		SOCIAL HISTORY None	
PHYSICAL EXAMINATION None		TOXICOLOGY None	
PATHOLOGICAL FINDINGS None		FORENSIC FINDINGS None	
SIGNATURE OF EXAMINER [Signature]		DATE 4-4-68	

1010 N. E. 10th St.
 Mobile, Ala.

RECEIVED
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
 APR 11 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
3
M
5100
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05021

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown rural 3		c. LENGTH OF STAY IN lb 40 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles William Black		4. DATE OF DEATH Month Day Year 4 12 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-1895
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) warehouseman		10b. KIND OF BUSINESS OR INDUSTRY P. R. R.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Luther S. Black		14. MOTHER'S MAIDEN NAME Euphemia Blose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 717-07-9361	
17. INFORMANT Mrs. Charlotte Black Hagerstown, Md. R3		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Bladder 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-1-59 to 4-12-60 , that (I) (we) last saw the deceased alive on 3-4-60 , and that death occurred at 1 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Fred W. Kraiss		22b. DATE SIGNED APR 18 '60	
22c. PHYSICIAN'S NAME (Type) DREW HITT		22d. ADDRESS Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4-14-60	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		25a. REC'D BY REGISTRAR APR 18 '60	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE William S. Kraiss	

151.0

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5068

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05022

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sharpsburg Md RFD #1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Rural Sharpsburg Md. RFD #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Duckett Last Bloom				4. DATE OF DEATH Month April Day 20 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 29 1873	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 0 Days 21		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tenant Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Tilghmanton Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John L. Bloom				14. MOTHER'S MAIDEN NAME Lydia Ann Harigan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217 18 1849		17. INFORMANT Address Mr. Milton R. Bloom Hagerstown Md RFD #3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced coronary atherosclerosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarction DUE TO unusual (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) under anesthesia for below knee amputation for gangrene of foot							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Edward W. Ditto III M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Edward W. Ditto III, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 23-60		22c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery		22d. LOCATION (City, town, or county) (State) Bakersville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert Lee Williamsport Maryland				24a. REC'D BY REGISTRAR APR 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John A. Wilson		RESIDENCE 1234 Main St., Baltimore, Md.	
DATE OF DEATH March 22, 1973		PLACE OF DEATH Home	
AGE 65		SEX Male	
RACE White		EDUCATION High School	
OCCUPATION Retired		MARRIAGE Married	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF EXAMINER [Signature]		DATE March 23, 1973	
LOCAL HEALTH DEPARTMENT Baltimore		COUNTY Baltimore	
STATE Maryland		FEDERAL BUREAU OF INVESTIGATION [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VP A15 (4)
ISM 9/59

1
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
05023
302
5069
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 2 Mos d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION W.Md. State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 341 South St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Middle Bell Last Bowers		4. DATE OF DEATH Month April Day 2 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 17 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin V.B. Green		14. MOTHER'S MAIDEN NAME Susan Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Virginia Corsi		Address 401 So Potomac St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia, bilateral DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cerebral thrombosis DUE TO 4 mos (c) general arteriosclerosis unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 9 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 4, 1960 to April 2, 1960 , that (I) (we) last saw the deceased alive on April 2, 1960 , and that death occurred at 6:57 AM , from the causes and on the date stated above.			
22a. SIGNATURE Victor L. Ramos, M.D.		22b. DATE SIGNED April 2, 1960	
22c. PHYSICIAN'S NAME (Type) Victor L. Ramos		22d. ADDRESS Western md. state Hospital, Hagerstown md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/5/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR APR 5 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur S. House	

CERTIFICATE OF DEATH

5000

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

REGISTRATION

1. Name of Deceased

2. Sex

3. Age

4. Date of Birth

5. Place of Birth

6. Cause of Death

7. Date of Death

8. Signature of Registrar

9. Signature of Doctor

10. Signature of Coroner

11. Name of Hospital

12. Name of Physician

13. Name of Coroner

14. Name of Registrar

15. Name of Doctor

16. Name of Coroner

17. Name of Registrar

18. Name of Doctor

19. Name of Coroner

20. Name of Registrar

21. Name of Doctor

22. Name of Coroner

23. Name of Registrar

24. Name of Doctor

25. Name of Coroner

5070
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05024

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b D.O.A. 03			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ALVIE LEROY BROWN				4. DATE OF DEATH Month Day Year April 3 1960 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12 1899	9. AGE (In years last birthday) yrs. 61	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Builder		11. BIRTHPLACE (State or foreign country) Thurmont Fred Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Reuben Brown				14. MOTHER'S MAIDEN NAME Miranda May Harbaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.# 2 291-01-8327		17. INFORMANT Address Mrs Madeline Brown 1049 Columbia Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) None						INTERVAL BETWEEN ONSET AND DEATH 1 hour No history of.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 3 1960 to April 3 1960 , that (I) (we) last saw the deceased alive on April 3 1960 , and that death occurred at 2 M, from the causes and on the date stated above.							
22a. SIGNATURE W. T. Layman				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) William T. Layman, M. D.,	
22d. ADDRESS 100 Professional Arts Bldg., Hagerstown, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/5/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md/	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				25a. REC'D BY REGISTRAR DATE APR 7 '60		25b. REGISTRAR'S SIGNATURE Arthur L. House	

CERTIFICATE OF DEATH

5070

Deceased's Name: [Illegible]

Registration Number: [Illegible]

Place of Birth: [Illegible]

Age: [Illegible]

Date of Death: [Illegible]

Place of Death: [Illegible]

Time of Death: [Illegible]

Sex: [Illegible]

Cause of Death: [Illegible]

Medical Officer: [Illegible]

Signature of Medical Officer: [Illegible]

Signature of Registrar: [Illegible]

Witnesses: [Illegible]

Registrar: [Illegible]

Remarks: [Illegible]

1 hour

None

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5071
CERTIFICATE OF DEATH

05025

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
f. STREET ADDRESS 225 W. Franklin St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALLEN Middle EUGENE Last CARPENTER		4. DATE OF DEATH Month April Day 19 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1958
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elwood Carpenter		14. MOTHER'S MAIDEN NAME Margaret Best	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Elwood Carpenter		Address Hagerstown, Md. 225 W. Franklin St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 344X Atelectasis, bilateral; with DUE TO cardiac failure (b) obstructive hydrocephalus (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 72 hr. 18 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 17, 1958, to Apr 19, 1960, that I last saw the deceased alive on Apr 19, 1960, and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward W. Dittmann M.D. 217 W. Washington St		DATE SIGNED 4/21/60	
PHYSICIAN'S NAME (Type) Edward W. Dittmann Hagerstown, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/23/60	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE APR 25 '60	
		24b. REGISTRAR'S SIGNATURE Charles S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5072
05026
302
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 8 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1917 Virginia Ave		d. STREET ADDRESS 1917 Virginia Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last IDA GERTRUDE CARTER		4. DATE OF DEATH Month Day Year April 13 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16 1872
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Brownsville Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John L. Mills		14. MOTHER'S MAIDEN NAME Lucy Gordon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Edward Q³ Carter 122 E. Main St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus; Arteriosclerosis, generalized.		INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) DECEASED attended the deceased from March 14, 1958 to Apr. 13, 1960 , that (I) (we) last saw the deceased alive on April 12, 1960 , and that death occurred at 10:15 P. M. from the causes and on the date stated above.			
22a. SIGNATURE W. T. Layman, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) W. T. Layman, M.D.		22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/16/60	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Was h Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Andrew K. Coffman Hagerstown Md.		25a. REC'D BY REGISTRAR DATE APR 18 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. K...	

420.8

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05027

5073

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 8 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 980 Northern Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BRAWNER Middle Last CATES, JR.				4. DATE OF DEATH Month April Day 8 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 8, 1923	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Managers				10b. KIND OF BUSINESS OR INDUSTRY plumbing whosaler		11. BIRTHPLACE (State or foreign country) Richmond, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Brawner Cates, Sr.				14. MOTHER'S MAIDEN NAME Ella Merchant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W.II		17. INFORMANT Mrs. Helen Cates		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dissecting Aortic Aneurysm 3 mo. (c) Rheumatic Heart Disease - old 30 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Vascular Disease							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN 29, 1960 to APRIL 8, 1960 , that (I) (we) lost saw the deceased alive on APRIL 8, 1960 , and that death occurred at 2:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Dorothy A. Hoffman M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/9/60	
22c. PHYSICIAN'S NAME (Type) Dorothy A. Hoffman				22d. ADDRESS 214 N. Pot. St. Hagerstown, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/11/1960		23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION (City, town, or county) (State) Richmond, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home H. Franklin Rouzer				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR APR 11 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1913

STATE OF NEW YORK

1913



[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "STATE OF NEW YORK" and "1913" are visible.]



may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. LUSBY
230 N. POTOMAC ST.

1
MAY 1960
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5074
CERTIFICATE OF DEATH

05028

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>03</u> <u>HAGERSTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>412 - REYNOLDS AVE.</u>				d. STREET ADDRESS <u>1412 REYNOLDS AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIE V. CLINE</u>				4. DATE OF DEATH Month Day Year <u>APRIL - 27 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 9. 1883</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BERRYVILLE VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE N. SPIELMAN</u>				14. MOTHER'S MAIDEN NAME <u>ANNA GOUFF</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. JOHN AUSER VIA 1412 REYNOLDS AVE HAGERSTOWN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Hypertensive-arterio Sclerotic Heart Disease with acute myocardial Failure</u> DUE TO (b) <u>5 yrs +</u> DUE TO (c) <u>5 yrs +</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs +</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>27 Apr 1960</u> , that (I) <u>last</u> saw the deceased alive on <u>27 Apr 1960</u> , and that death occurred at <u>9:15 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>F. F. Lusby</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>29 April 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>				22d. ADDRESS <u>230 N. Potomac St</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APR 30 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Baet</u>				ADDRESS <u>BOONSBORO MD</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 5 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

5034

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF REGISTRAR
OFFICE OF REGISTRAR

1. Name of deceased
2. Age
3. Sex
4. Race
5. Date of birth
6. Place of birth
7. Date of death
8. Place of death
9. Cause of death
10. Manner of death
11. Signature of registrar
12. Office of registrar

1. Name of deceased
2. Age
3. Sex
4. Race
5. Date of birth
6. Place of birth
7. Date of death
8. Place of death
9. Cause of death
10. Manner of death
11. Signature of registrar
12. Office of registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
M
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5075
05029
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. State Hospital		MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont d. STREET ADDRESS 10X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Queenie Middle A. Last Cook		4. DATE OF DEATH Month April Day 24 Year 1960							
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1867	9. AGE (In years lost birthday) 93 yrs.	10. IF UNDER 1 YEAR Months 93	11. IF UNDER 24 HRS. Days 93	12. IF UNDER 24 HRS. Hours 93	13. IF UNDER 24 HRS. Min. 93	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Davis		14. MOTHER'S MAIDEN NAME Susan Wilhide		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Goldie Anders Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia, bilateral DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cardiac decompensation (b) General Arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 30, 1960 to April 24, 1960 that (I) (we) last saw the deceased alive on April 24, 1960 , and that death occurred at 5:30 PM , from the causes and on the date stated above.								22b. DATE SIGNED April 24, 1960	
22a. SIGNATURE Victor L. Ramos		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS		22d. ADDRESS Western Md. State Hospital, Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-26-60		23c. NAME OF CEMETERY OR CREMATORY United Brethern Cem.		23d. LOCATION (City, town, or county) (State) Thurmont, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Maryland		25a. REC'D BY REGISTRAR APR 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Huns			

CERTIFICATE OF DEATH

103

Washington

Maryland

Interment

Interment

Interment, State No. 121

Jan. 1, 1907

Female

Interment

Own home

Interment

U.S.A.

Interment

Interment

Interment, State No. 121

Interment

Interment, Maryland

Interment, Maryland

103-50

Interment

Interment, Maryland, State No. 121

Interment, Maryland, State No. 121

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5076

CERTIFICATE OF DEATH

05030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) 090 GORNSHED MEM. CONV. HOME		e. STREET ADDRESS 1915 DEWEY AVE.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NETTIE Middle CATHERINE Last CROMER		4. DATE OF DEATH Month APRIL Day 4 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/11/1880	9. AGE (In years lost birthday) 79 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ABRAHAM RHODES		14. MOTHER'S MAIDEN NAME MARGARET FORTHMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-7576		17. INFORMANT MRS. CATHERINE BLACKBURN Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease with DUE TO Myocardial failure (c) 16 yrs					INTERVAL BETWEEN ONSET AND DEATH 7 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , 19 4 Apr , to 1960 , that I last saw the deceased alive on 4 Apr , 19 60 , and that death occurred at 247 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE F. J. Lusby M.D. 230 N. Thomas DATE SIGNED 5 Apr 60 PHYSICIAN'S NAME (Type) F. J. Lusby Hagerstown					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/6/60		22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.	
22d. LOCATION (City, town, or county) HAGERSTOWN		(State) MD.			
23. BURIAL DIRECTOR'S SIGNATURE W. J. Horne		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE APR 7 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume					

ASU 1130AM

3502

CENTRAL OF CALIF

3502

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5101 CERTIFICATE OF DEATH

Reg. Dist. No.

05031

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Hagerstown #5</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Smithsburg #2, near Hag.</u>			
c. LENGTH OF STAY IN 1b <u>2 1/2</u> Years				d. STREET ADDRESS <u>Smithsburg #2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hagerstown #5</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>L.</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 24, 1877</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>82</u> Days <u>15</u> Hours <u>15</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		11. BIRTHPLACE (State or foreign country) <u>Lantz Md.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Samuel Pryor</u>		14. MOTHER'S MAIDEN NAME <u>Louise Kline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. G. Calvin Shoop, Hagerstown Md., #5</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Congestive failure</u> DUE TO (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Small artery sclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>1950</u> to <u>April 15, 1960</u> , that I last saw the deceased alive on <u>April 13, 1960</u> , and that death occurred at <u>Md.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. David R. Hess</u> M.D.				ADDRESS (Street, city or town, state) <u>Smithsburg #5, Franklin Co., Pa.</u> DATE SIGNED <u>Apr 18 '60</u>			
PHYSICIAN'S NAME (Type) <u>Dr. David R. Hess</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/17/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harbaugh's</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg #5, Franklin Co., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Z. Shoop, Waynesboro Pa.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>APR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

260X

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5077

05032

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>3 DAYS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>081 WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>NO. 6 S. CANNON AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ADAM SAMUEL DIETERICH</u>				4. DATE OF DEATH Month Day Year <u>APRIL - 29 - 19 60</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 24 - 1891</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>8 5</u>		IF UNDER 24 HRS. <u>8 5</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PANGBORN CORP.</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>SAMUEL DIETERICH</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA VANDREAU</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>U.S. NAVY</u>				16. SOCIAL SECURITY NO. <u>217-18-7872</u>		17. INFORMANT <u>MRS. MABLE DIETERICH</u> Address <u>NO. 6 S. CANNON AVE HAGERSTOWN MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis and vascular hypertension</u> DUE TO <u>hypertension</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u> Undetermined							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 11 1958</u> to <u>April 29 1960</u> , that (I) (we) last saw the deceased alive on <u>April 29 1960</u> , and that death occurred at <u>11:10 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>B. B. Kneisley</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 2, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>				22d. ADDRESS <u>148 West Washington Street Hagerstown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 13, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>				ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 5 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

2003

CERTIFICATE OF DEATH

2003

10

[Faint, illegible text and lines, likely a form or document, possibly a certificate of death as indicated by the header. The text is mirrored and difficult to read.]

5078

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 35 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown, R.F.D.#1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. James Washington County Hospital		d. STREET ADDRESS 307 Robinwood Drive.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle Karl Last Dinkel		4. DATE OF DEATH Month April Day 11 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21 1893
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.	IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY N. American Cement	11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George M. Denkel		14. MOTHER'S MAIDEN NAME Louise Krauss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-6826	
INFORMANT Catherine Dinkel		Address Hagerstown, R.D. 1 Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary artery occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 3 hours Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 11, 1960 to April 11, 1960 that I last saw the deceased alive on April 11, 1960 , and that death occurred at 2:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lawrence L. Packer Jr.		ADDRESS (Street, city or town, state) 145 W. Washington, St. Hagerstown, Md.	
PHYSICIAN'S NAME (Type) Lawrence L. Packer Jr.		DATE SIGNED 4/12/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/60	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Washing Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Hagerstown, Md.		ADDRESS 424. REC'D BY REGISTRAR	
DATE APR 18 '60		24b. REGISTRAR'S SIGNATURE Catherine L. Krauss	

2500

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05034

5079

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 42 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. STREET ADDRESS 1201 W. WASHINGTON ST.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARRIE Middle BLANCHE Last DOFFLEMYER				4. DATE OF DEATH Month APRIL Day 11 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/8/1882	
9. AGE (In years last birthday) 77 yrs.		10. UNDER 1 YEAR Months 7 Days 11 Hours 19 Min.		11. UNDER 24 HRS. Months 7 Days 11 Hours 19 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME PENDLETON KIBLER				14. MOTHER'S MAIDEN NAME DOROTHY ANNE STRICKLER BURG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. GENEVIEVE BAADTE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c) Diabetes mellitus Hypertension				INTERVAL BETWEEN ONSET AND DEATH Immediate 18 yrs 6 yrs 6 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Oct. 19 47 , to April 11 19 60 , that I last saw the deceased alive on April 2 19 60 , and that death occurred at 4 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip J. Hirshman				ADDRESS (Street, city or town, state) 159 W. Washington St., Hagerstown, Md. DATE SIGNED 4/14/60			
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland							
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		22b. DATE THEREOF 4/14/60		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.				24a. REC'D BY REGISTRAR Apr 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

X007

1

05035

5102 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna.</u> b. COUNTY <u>Cumberland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R.D. 5</u>				c. LENGTH OF STAY IN 1b <u>6 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shiremanstown</u> <u>75X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brook Lane Farm</u>				d. STREET ADDRESS <u>12 S. Stoner Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle _____ Last <u>Doner</u>				4. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 15, 1878</u>	
9. AGE (In years last birthday) yrs. <u>81</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>New York State</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Andrew Herr</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Eshelman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Mark L. Winger Shiremanstown, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arrival at Shiremanstown, Pa. Sunday</u> DUE TO (b) <u>Cardiac Decompensation</u> <u>1 week</u> DUE TO (c) <u>Hypertensive Cardio Vascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While _____ Not while _____ of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>3/14</u> 19 <u>60</u> , to <u>April 25</u> 19 <u>60</u> , that I last saw the deceased alive on <u>April 25</u> 19 <u>60</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Brook Lane Farm Hagerstown R.D. 5 Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>John C. White</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>Edward W. Dittus III, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mechanicsburg Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Mechanicsburg Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin L. Myess</u>				ADDRESS <u>Mechanicsburg, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>Apr 27 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kimes</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, TO FUNERAL DIRECTOR: page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 15, 1885</u></p>		<p>4. Age: <u>35</u> years</p>	
<p>5. Place of birth: <u>St. Louis, Mo.</u></p>		<p>6. Date of death: <u>Jan 20, 1920</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Immediate cause: <u>Myocardial infarction</u></p>	
<p>9. Duration of illness: <u>2 weeks</u></p>		<p>10. Place of death: <u>Home</u></p>	
<p>11. Name of physician: <u>Dr. J. H. Smith</u></p>		<p>12. Name of informant: <u>John J. Smith</u></p>	
<p>13. Address of deceased: <u>1234 Main St., Baltimore, Md.</u></p>		<p>14. Address of informant: <u>1234 Main St., Baltimore, Md.</u></p>	
<p>15. Signature of physician: <u>J. H. Smith</u></p>		<p>16. Signature of informant: <u>John J. Smith</u></p>	

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the informant, and is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND

5103 **CERTIFICATE OF DEATH** **302 05036**
 Item 8 Film 261 4-20-60 et

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 6				c. LENGTH OF STAY IN 1b 3Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lappans Cross Roads				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GRACE Middle PEARL Last DORSEY				4. DATE OF DEATH Month April Day 14 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14 1960	
9. AGE (In years lost birthday) 40 yrs.		10a. USUAL OCCUPATION (Give kind of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Princeton Mercer Co Pa	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME William H. Kessinger			
14. MOTHER'S MAIDEN NAME Susie Grubb				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No			
16. SOCIAL SECURITY NO. -----				17. INFORMANT Harry P. Dorsey 116 No Jonathan St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy (15 years) (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 days 6 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Jan 1 1960 to 4-14 1960 that (I) (we) last saw the deceased alive on 4-14 1960 , and that death occurred at 2 PM , from the causes and on the date stated above.							
22a. SIGNATURE Robert P. Conrad				22b. DATE SIGNED 4-15-60		22c. PHYSICIAN'S NAME (Type) Robert P. Conrad	
22d. ADDRESS 137 W. Wash. Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/16/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Toffman				25a. REC'D BY REGISTRAR APR 18 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

X133

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
M
081
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5080
05037
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mamie Middle E Last Dye				4. DATE OF DEATH Month 4 Day 24 Year 19 60			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1903	
9. AGE (In years lost birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Lang				14. MOTHER'S MAIDEN NAME Nettie Deavers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Miss Brenda L. Dye Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X METASTATIC CA OF BRAIN DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adeno-ca OF UTERUS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 1 Mo. 6 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb 2, 1960 to April 24, 1960 , that (I) was last saw the deceased alive on April 24, 1960 , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE John A. Moran M.D.				22b. DATE SIGNED 4/25/60			
22c. PHYSICIAN'S NAME (Type) JOHN A. MORAN M.D.				22d. ADDRESS 215 W. WASHINGTON ST. HAGERSTOWN			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4-27-60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE APR 26 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Krauss			

THE UNIVERSITY OF CHICAGO PRESS

5. *Explain the importance of the following:*

6-75-

U.S. National Library of Medicine

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5104

CERTIFICATE OF DEATH

Reg. Dist. No.

05038

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown				c. LENGTH OF STAY IN 1b 35 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hagerstown Rt. 5				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Perry Middle --- Last Forcino				4. DATE OF DEATH Month April Day 14 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 7, 1905		9. AGE (In years last birthday) yrs. 55	10. IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min. 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement mixer				10b. KIND OF BUSINESS OR INDUSTRY cement mill		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Giosia Forcino			
14. MOTHER'S MAIDEN NAME Elevia Schiazzo				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. 11			
16. SOCIAL SECURITY NO. 213-10-6774				17. INFORMANT Address Mrs. Margaret C. Forcino Rt. 5			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis DUE TO Arterio sclerosis (c) Arterio sclerosis						INTERVAL BETWEEN ONSET AND DEATH 30 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown				20g. (County) Hagerstown		20h. (State) Md.	
21. I certify that I attended the deceased from 2 June , 19 57 , to 14 April , 19 60 ; that I last saw the deceased alive on 4 April , 19 60 , and that death occurred at 6-4 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Eldon G. Hoachlander				ADDRESS (Street, city or town, state) 115 W. Washington St. DATE SIGNED 14 April 1960			
PHYSICIAN'S NAME (Type) Eldon G. Hoachlander				Hagerstown Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-60		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE APR 18 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

420.1

Washington

Hotel Lafayette

Lafayette Hotel

Room

Male

Cement mixer

Global Torino

Yes

W. F. II

Kiev

Mr. Lawrence G. Torino

Italy

U. S. A.

Torino

April

1960

Jan. 7, 1965

SS

Lafayette

Hotel Lafayette

Lafayette Hotel

Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

3081

5081

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH 302

05039

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 3 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg d. STREET ADDRESS Antietam St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUTH NUNAMAKER FOREMAN		4. DATE OF DEATH April 6 1960 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23 1893 yrs.
9. AGE (In years last birthday) 67		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eavey Nunamaker		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Careyle M. Foreman		Address 453 W. Antietam St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO cardiovascular collapse Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial failure DUE TO arteriosclerosis (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none except stroke 12 hr. ago		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from apr. 1960 to apr. 6 1960 , that (I) (we) last saw the deceased alive on apr. 5 1960 , and that death occurred at 3 PM , from the causes and on the date stated above.			
22a. SIGNATURE Louis G. Graff		22b. DATE SIGNED 4-8-60	
22c. PHYSICIAN'S NAME (Type) LOUIS G. GRAFF M.D.		22d. ADDRESS 119 E. Antietam St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/9/60	
23c. NAME OF CEMETERY OR CREMATORY rose hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR APR 11 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05040
 Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 1 Hr	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maugansville			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greencastle Pike				d. STREET ADDRESS North Ave			
3. NAME OF DECEASED (Type or print) First CHARLES Middle SELVA Last FOSTER Sr				4. DATE OF DEATH Month April Day 12 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4 1899		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Fairchild Corp		11. BIRTHPLACE (State or foreign country) PA Enid Fulton Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thornton Foster				14. MOTHER'S MAIDEN NAME Susan Truax			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 161-12-7620		17. INFORMANT Charles S. Foster Jr Hagerstown R # 2 Address Greencastle Pike			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 3 yrs							INTERVAL BETWEEN ONSET AND DEATH 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/15/60		22c. NAME OF CEMETERY OR CREMATORY Wells Valley U.B. Cemetery New Granada Fulton Co	
22d. LOCATION (City, town, or county) Pa (State)							
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR APR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

420.0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
M
X
I
O
1
5105
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05041

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Md		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Graves Last Francis		4. DATE OF DEATH Month 4 Day 23 Year 19 60	
5. SEX W F	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7.2.1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR: Months 9 Days 21 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Washington Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley Brumback		14. MOTHER'S MAIDEN NAME Elizabeth Long	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Thomas A Francis Hancock Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO (b) Arterio Sclerotic DUE TO (c) Cardio Vasc disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. INTERVAL BETWEEN ONSET AND DEATH 3mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr 22 1960 to Apr 23 1960 that (I) (we) last saw the deceased alive on Apr 23 1960 and that death occurred at 2 PM , from the causes and on the date stated above.			
22a. SIGNATURE L. Shaffer		22b. DATE SIGNED 4/27/60	
22c. PHYSICIAN'S NAME (Type) L. SHAFER Hancock		22d. ADDRESS Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4.27.60	
23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION (City, town, or county) (State) Hancock Washington Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard F Stone Hancock Md		25a. REC'D BY REGISTRAR DATE APR 29 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kinas			

2011

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5106

CERTIFICATE OF DEATH

05042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg c. LENGTH OF STAY IN Tb 12 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 128 E. Main St				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg d. STREET ADDRESS 128 E. Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Vena Middle Lee Last Furry				4. DATE OF DEATH Month April Day 2 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 22, 1868	
9. AGE (In years lost birthday) 92 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Funkstown Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME William Furry				14. MOTHER'S MAIDEN NAME Amelia Mc Coy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <input type="checkbox"/>		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Atherosclerotic Heart DUE TO (b) 3 yrs. Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (c) 3 yrs. DUE TO (c) 3 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 5, 1960 to April 2, 1960 , that I last saw the deceased alive on Monday 20, 1960 , and that death occurred at 6 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. Lellan M.D.				ADDRESS (Street, city or town, state) Boonsboro DATE SIGNED 4/2/60			
PHYSICIAN'S NAME (Type) Gerald Le Van				Boonsboro Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-4-60		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son ADDRESS Hagerstown Md.				24a. REC'D BY REGISTRAR DATE APR 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

5110

Washington

Charleston

128 E. Main St.

Van

Female White

House Work

William Perry

Annie M. Fox

March 21, 1908

Punkston

128 E. Main St.

Charleston

Washington

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5083

Item 23 B- Film G262 5/4/60 1wk

05043

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 15 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24 Broadway		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 1 24 Broadway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PROBERT Middle WOODFORD Last GRADY		4. DATE OF DEATH Month April Day 29 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1897
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min. 62	IF UNDER 24 HRS. Months 62 Days 62 Hours 62 Min. 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Electrical Wholesaler	
11. BIRTHPLACE (State or foreign country) Goldsboro, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry G. Grady		14. MOTHER'S MAIDEN NAME Claudia E. Perkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577-05-6366	
17. INFORMANT Mrs. Opal Grady		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 7 years DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity, Exaggerated Sympathetic Innervation			INTERVAL BETWEEN ONSET AND DEATH 7 years
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-18-53 19 to 4-29 1960 that (I) (we) last saw the deceased alive on 4-29 1960, and that death occurred at 2 M, from the causes and on the date stated above.			
22a. SIGNATURE Salmon Welty		22b. ADDRESS 998 Potomac Cir. Hagerstown, Md	
22c. PHYSICIAN'S NAME (Type) DALTON M. WELTY		22d. ADDRESS 998 Potomac Cir. Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 1, 1960	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City, town, or county) (State) Hagerstown Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home		25. REC'D BY REGISTRAR MAY 2 '60	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

5023



Commonwealth of Massachusetts

County, Essex; District, South

4-18-23 4-24 60

4-24 60

1928 Boston Co. Registration

BALTIMORE WELTY
BALTIMORE WELTY

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05044

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 40 East		d. STREET ADDRESS Route 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alfred Middle Gordon Last Graff		4. DATE OF DEATH Month April Day 1 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1895
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY House Building	
11. BIRTHPLACE (State or foreign country) Stratford Canada		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William H. Graff		14. MOTHER'S MAIDEN NAME Caroline Zinn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 284-16-9202	
17. INFORMANT Mrs. Adela M. Graff Hag. Rt. 1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION, ATHEROSCLEROTIC DUE TO Conditions, if any, which gave rise to immediate cause (b) MYOCARDIAL INFARCTION, POSTERIOR LT. VENTRICLE (c) LEFT VENTRICULAR HYPERTROPHY cause last.		INTERVAL BETWEEN ONSET AND DEATH Instant sev. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. W. Ditto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. W. Ditto, Jr., M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/2/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-6-60	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR APR 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5084

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Film G261-4/27/60-Items 8 & 10-mnb

Reg. Dist. No.

05045

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN lb 4 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Western Md. Chronic Disease Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton	
3. NAME OF DECEASED (Type or print) First Middle Last Dale Frederick Graham		4. DATE OF DEATH Month Day Year 4 24 1960	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/14 5/6/1914
9. AGE (In years last birthday) 45		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi driver Cartographer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Graham		14. MOTHER'S MAIDEN NAME Bessie E. Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-07-4778	
17. INFORMANT Application for admission-Western Md. Hosp.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia - lower lobes bilateral DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. Fracture skull with cortical laceration.		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Penetrating gunshot wound of head - self inflicted.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Penetrating gunshot wound of head - self inflicted		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) Penetrating gunshot wound of head - self inflicted	
20c. TIME OF INJURY Month, Day, Year Hour 3:00 PM 8-2 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Wheaton, Montgomery Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Edward W. Ditto, III, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/25/60	
EXAMINER'S NAME (Type) Edward W. Ditto, III, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/60	
22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Prince Georges County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters		ADDRESS 2254 Capitol ST NW, DC	
24a. REC'D BY REGISTRAR DATE APR 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

5085

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05047

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#6	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		d. STREET ADDRESS Near Frederick	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALBERT Middle KENT Last HARMON		4. DATE OF DEATH Month APRIL Day 7 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Nov 1912
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tenant		10b. KIND OF BUSINESS OR INDUSTRY Dairy Farm	
11. BIRTHPLACE (State or foreign country) Nebo, Va.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Rush F. Harmon		14. MOTHER'S MAIDEN NAME Ada Paxton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-26-1005	
17. INFORMANT Mrs. Julia E. Harmon (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia, bilateral 744.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Progressive muscular Dystrophy DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 10 days 14 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 8, 1959 , to April 7, 1960 , that (I) (we) last saw the deceased alive on April 7, 1960 , and that death occurred at 6:10 AM, from the causes and on the date stated above.			
22a. SIGNATURE George Bercu		22b. DATE SIGNED April 7, 1960	
22c. PHYSICIAN'S NAME (Type) DR. GEORGE BERCU		22d. ADDRESS 1500 PENNSYLVANIA AVE. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-11-60	
23c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR APR 11 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

CERTIFICATE OF DEATH

501

7

DECEASED

LASTING

WITNESSES

REGISTERED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED



DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5087

CERTIFICATE OF DEATH

05048
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	c. LENGTH OF STAY IN 1b 50 YRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 1266 HAGER ST.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CHESTER Middle WILLIAM Last HARTLE		4. DATE OF DEATH Month APRIL Day 26 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/1889
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY CIRY WATER PLANT	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CLINTON HARTLE	
14. MOTHER'S MAIDEN NAME MASIE SCHILDTNECHT		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 214-09-6978A		INFORMANT MRS. BEULAH W. HARTLE Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Myocardial Infarction DUE TO Arteriosclerosis (c) General		INTERVAL BETWEEN ONSET AND DEATH Immediately 3 yrs. 3 yrs. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 15 , 19 57 to April 26 , 19 60 , that I last saw the deceased alive on April 9 , 19 60 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 159 W. Washington St. Hagerstown DATE SIGNED 4/27/60 ACTUAL SIGNATURE Philip J. Hirshman M.D. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/29/60	22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horne		24a. REC'D BY REGISTRAR DATE MAY 2 '60	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kross	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

501

7

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
M

5088

05049

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 5 weeks d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Kitzmiller d. STREET ADDRESS Star Route e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle M. Last HARVEY		4. DATE OF DEATH Month APRIL Day 16 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1871
9. AGE (In years birthday) 88 yrs.		IF UNDER 1 YEAR Months 88 Days 16 Hours 19 Min. 60	IF UNDER 24 HRS. Months 88 Days 16 Hours 19 Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, Coal mines,		10b. KIND OF BUSINESS OR INDUSTRY Farm, Etc.	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Harvey		14. MOTHER'S MAIDEN NAME Elizabeth Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Address Mrs. William Harvey Kitzmiller, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA LOWER LOBES BILATERAL DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF PROSTATE WITH METASTASES DUE TO 10 YRS. (c) 7 DAYS		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SQUAMOUS CELL CARCINOMA OF SKIN		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAR. 11, 1960 to APRIL 16, 1960 , that (I) (we) last saw the deceased alive on APRIL 16, 1960 , and that death occurred at 4:05 PM , from the causes and on the date stated above.			
22a. SIGNATURE George Beren		22b. DATE SIGNED 4/16/60	
22c. PHYSICIAN'S NAME (Type) DR. GEORGE BERCU		22d. ADDRESS 1500 PENNSYLVANIA AVE. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/18/1960	
23c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		23d. LOCATION (City, town, or county) (State) Deer Park, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. Leighton Oakland Md.		25a. REC'D BY REGISTRAR APR 19 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

99/1

CERTIFICATE OF DEATH

2023

Name of Deceased		Date of Birth	
John Doe		1950-01-01	
Sex		Male	
Race		White	
Usual Residence		123 Main St, New York, NY	
Place of Death		New York State Hospital	
Cause of Death		Heart Disease	
Date of Death		2023-01-15	
Time of Death		10:00 AM	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Signature of Family Member		[Signature]	

5089

CERTIFICATE OF DEATH

Reg. Dist. No.

05050

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Myersville</u> 10X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>Route # 2</u>	
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>K.</u> Last <u>HAYS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 7, 1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own chicken farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Allen Hays</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Kline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-12-2404</u>	
17. INFORMANT <u>Mrs. Oscar Delauter</u>		Address <u>Rt. # 2</u> <u>Myersville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Aneurysm of vertebral artery</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>10 yrs.</u> <u>7 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Abscess of cerebellum, thrombus of rt. venous sinus of brain</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-16-56</u> 19 <u>56</u> , to <u>4-23-60</u> 19 <u>60</u> , that I last saw the deceased alive on <u>4-22-60</u> 19 <u>60</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4-25-60</u>	
ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D.		DATE SIGNED <u>4-25-60</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>		<u>Smithsburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 26, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Wolfsville, Fred. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul F. Bittie</u>		24a. REC'D BY REGISTRAR <u>APR 28 '60</u>	
ADDRESS <u>Myersville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hess</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420-1

5090

CERTIFICATE OF DEATH

Reg. Dist. No.

05051

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Distinct before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Henson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1960</u>
9. AGE (In years lost birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR Months <u>-</u> Days <u>24</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bud Hutzell</u>		14. MOTHER'S MAIDEN NAME <u>Bettie Elizabeth Henson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Harry Thurman Henson</u>		18. R.F.D. # <u>1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 Day</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/13/60</u> to <u>4/14/60</u> , that I last saw the deceased alive on <u>4/14/60</u> at <u>19</u> , and that death occurred at <u>4:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph Young</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Williamsport, Md</u> <u>4/15/60</u>	
PHYSICIAN'S NAME (Type) <u>Albert L. Leaf Williamsport, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 16, '60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bakersville Cemetery Bakersville, Maryland</u>	22d. LOCATION (City, town, or county) (State) <u>Bakersville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 18 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000181XV3

DISCUSSION

поэтому

1970-1975

YES: 5

1986-1987

Washington County Hospital

... ..

Cò

41

CONET

25

1001, Elmore

and

one.

12/2/78

Pattie Mitchell Hannon

Control by

[illegible]

000000

[illegible]

1224

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

5108

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05052

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport c. LENGTH OF STAY IN 1b 2 years 6 months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hampton Road West		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport (Mt. Tammany) d. STREET ADDRESS Hampton Road West e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAURICE EDGAR HESS First Middle Last		4. DATE OF DEATH April 17 1960 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 22, 1874 9. AGE (In years last birthday) 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Finisher		10b. KIND OF BUSINESS OR INDUSTRY Furniture Manufacturer Taneytown, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Hess		14. MOTHER'S MAIDEN NAME Agnes J. Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-6930	
17. INFORMANT Mrs. Margaret Hess Williamsport, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic cardio-vascular disease DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign hypertrophy of prostate INTERVAL BETWEEN ONSET AND DEATH 5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 16 1960 to April 17 1960 that (I) (we) last saw the deceased alive on April 16 1960 , and that death occurred at 1:15 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Walter Layman M.D.		22b. DATE SIGNED April 18, 1960	
22c. PHYSICIAN'S NAME (Type) J. Walter Layman, M. D.,		22d. ADDRESS Hagerstown, Maryland 100 Professional Arts Bldg.,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/19/1960	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home P. Franklin Perry		25a. REC'D BY REGISTRAR APR 21 '60 DATE	
ADDRESS Hagerstown, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

CERTIFICATE OF TRAINING

5103



Form with multiple sections and fields, including names, dates, and organizational affiliations. The text is mirrored and difficult to read.

NAME: [Illegible]
DATE: [Illegible]
ORGANIZATION: [Illegible]
[Additional illegible text and fields follow in a structured layout.]

05053

5024 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MATYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 60 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 266 S. POTOMAC ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JONAS Middle LEE Last HOCKMAN		4. DATE OF DEATH Month APRIL Day 10 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/7/1865
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months 9 Days 2 Hours 0 Min.	11. IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JONAS LEE HOGKMAN		14. MOTHER'S MAIDEN NAME ELIZA COVERSTONE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not known) <input type="checkbox"/> (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS CLARA H. KARN		HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease. DUE TO (c) ?			INTERVAL BETWEEN ONSET AND DEATH 36 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 9, 1960 to April 10, 1960 that I last saw the deceased alive on April 9, 1960 and that death occurred at 9:19P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. A. Bell		ADDRESS (Street, city or town, state) DATE SIGNED 119 N. Potomac Street, 4/12/60.	
PHYSICIAN'S NAME (Type) R. A. BELL, M.D.		Hagerstown, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/13/60	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horowitz, Hagerstown, Md.		24a. REC'D BY REGISTRAR APR 18 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420

05054
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. Co. HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u> d. STREET ADDRESS <u>435 W. FRANKLIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EARL FRANKLIN HOLMES</u>		4. DATE OF DEATH Month Day Year <u>APRIL - 5 - 1960</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 2 - 1897</u>	
9. AGE (In years last birthday) <u>62 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>QUARTERMASTER</u>	
11. BIRTHPLACE (State or foreign country) <u>FAIRCHILD AIRCRAFT CHESTNUT GROVE WASH CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NELSON HOLMES</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W. I</u>		16. SOCIAL SECURITY NO. <u>220 09-9134</u>	
17. INFORMANT <u>MRS ESTA HOLMES</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Diabetes</u> DUE TO (c) <u>General arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>J. E. W. D. T. O. J.</u> EXAMINER'S NAME (Type) <u>J. E. W. D. T. O. J.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR. 8, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Baet</u>		24a. REC'D BY REGISTRAR <u>APR 12 1960</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Kram</u>		24c. ADDRESS <u>BOONSBORO MD.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

262

W. T. T.
EST
15

5092

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Greencastle</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> <u>3 mi S.W.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> <u>75x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		d. STREET ADDRESS <u>3075 Ridge Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>Homer</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 9, 1883</u> 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Greencastle, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>D. W. Homer</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Feldman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mrs. Mary Homer - Greencastle, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular accident</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>1</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 1</u> , 19 <u>60</u> to <u>April 26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 26</u> , 19 <u>60</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. E. Byrkit</u> M.D.		ADDRESS (Street, city or town, state) <u>284 Potomac</u> DATE SIGNED <u>4-26-60</u>	
PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>		<u>Williamsport Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/29/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>near Greencastle Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Munnich</u> ADDRESS <u>Greencastle</u>		24a. REC'D BY REGISTRAR DATE <u>APR 29 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

DATE

TIME

PLACE

BY

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

PREVIOUS MARRIAGE

PREVIOUS CHILDREN

PREVIOUS DEATHS

PREVIOUS MENTAL ILLNESS

PREVIOUS PHYSICAL ILLNESS

PREVIOUS SURGERY

PREVIOUS DRUG ABUSE

PREVIOUS ALCOHOL ABUSE

PREVIOUS TUBERCULOSIS

PREVIOUS SYPHILIS

PREVIOUS GONORRHEA

PREVIOUS CHLAMYDIA

PREVIOUS HIV INFECTION

PREVIOUS AIDS

PREVIOUS CANCER

PREVIOUS HEART DISEASE

PREVIOUS DIABETES

PREVIOUS HYPERTENSION

PREVIOUS ASTHMA

PREVIOUS COPD

PREVIOUS CHRONIC KIDNEY DISEASE

PREVIOUS LIVER DISEASE

PREVIOUS PANCREATITIS

PREVIOUS GALLBLADDER DISEASE

PREVIOUS APPENDICITIS

PREVIOUS DIVERTICULITIS

PREVIOUS IBS

PREVIOUS CROHN'S DISEASE

PREVIOUS ULCERS

PREVIOUS GASTRITIS

PREVIOUS GERD

PREVIOUS ACID REFLUX

PREVIOUS HEMORRHOIDS

PREVIOUS CRACKS

PREVIOUS ECZEMA

PREVIOUS PSORIASIS

PREVIOUS DERMATITIS

PREVIOUS ALLERGIES

PREVIOUS FOOD ALLERGIES

PREVIOUS DRUG ALLERGIES

PREVIOUS ENVIRONMENTAL ALLERGIES

PREVIOUS ANIMAL ALLERGIES

PREVIOUS POLLEN ALLERGIES

PREVIOUS MOLD ALLERGIES

PREVIOUS DUST ALLERGIES

PREVIOUS INSECT ALLERGIES

PREVIOUS BLOOD TYPE

PREVIOUS RH FACTOR

PREVIOUS HIV STATUS

PREVIOUS AIDS STATUS

PREVIOUS CANCER STATUS

PREVIOUS HEART DISEASE STATUS

PREVIOUS DIABETES STATUS

PREVIOUS HYPERTENSION STATUS

PREVIOUS ASTHMA STATUS

PREVIOUS COPD STATUS

PREVIOUS CHRONIC KIDNEY DISEASE STATUS

PREVIOUS LIVER DISEASE STATUS

PREVIOUS PANCREATITIS STATUS

PREVIOUS GALLBLADDER DISEASE STATUS

PREVIOUS APPENDICITIS STATUS

PREVIOUS DIVERTICULITIS STATUS

PREVIOUS IBS STATUS

PREVIOUS CROHN'S DISEASE STATUS

PREVIOUS ULCERS STATUS

PREVIOUS GASTRITIS STATUS

PREVIOUS GERD STATUS

PREVIOUS ACID REFLUX STATUS

PREVIOUS HEMORRHOIDS STATUS

PREVIOUS CRACKS STATUS

PREVIOUS ECZEMA STATUS

PREVIOUS PSORIASIS STATUS

PREVIOUS DERMATITIS STATUS

PREVIOUS ALLERGIES STATUS

PREVIOUS FOOD ALLERGIES STATUS

PREVIOUS DRUG ALLERGIES STATUS

PREVIOUS ENVIRONMENTAL ALLERGIES STATUS

PREVIOUS ANIMAL ALLERGIES STATUS

PREVIOUS POLLEN ALLERGIES STATUS

PREVIOUS MOLD ALLERGIES STATUS

PREVIOUS DUST ALLERGIES STATUS

PREVIOUS INSECT ALLERGIES STATUS

PREVIOUS BLOOD TYPE STATUS

PREVIOUS RH FACTOR STATUS

PREVIOUS HIV STATUS STATUS

PREVIOUS AIDS STATUS STATUS

PREVIOUS CANCER STATUS STATUS

PREVIOUS HEART DISEASE STATUS STATUS

PREVIOUS DIABETES STATUS STATUS

PREVIOUS HYPERTENSION STATUS STATUS

PREVIOUS ASTHMA STATUS STATUS

PREVIOUS COPD STATUS STATUS

PREVIOUS CHRONIC KIDNEY DISEASE STATUS STATUS

PREVIOUS LIVER DISEASE STATUS STATUS

PREVIOUS PANCREATITIS STATUS STATUS

PREVIOUS GALLBLADDER DISEASE STATUS STATUS

PREVIOUS APPENDICITIS STATUS STATUS

PREVIOUS DIVERTICULITIS STATUS STATUS

PREVIOUS IBS STATUS STATUS

PREVIOUS CROHN'S DISEASE STATUS STATUS

PREVIOUS ULCERS STATUS STATUS

PREVIOUS GASTRITIS STATUS STATUS

PREVIOUS GERD STATUS STATUS

PREVIOUS ACID REFLUX STATUS STATUS

PREVIOUS HEMORRHOIDS STATUS STATUS

PREVIOUS CRACKS STATUS STATUS

PREVIOUS ECZEMA STATUS STATUS

PREVIOUS PSORIASIS STATUS STATUS

PREVIOUS DERMATITIS STATUS STATUS

PREVIOUS ALLERGIES STATUS STATUS

PREVIOUS FOOD ALLERGIES STATUS STATUS

PREVIOUS DRUG ALLERGIES STATUS STATUS

PREVIOUS ENVIRONMENTAL ALLERGIES STATUS STATUS

PREVIOUS ANIMAL ALLERGIES STATUS STATUS

PREVIOUS POLLEN ALLERGIES STATUS STATUS

PREVIOUS MOLD ALLERGIES STATUS STATUS

PREVIOUS DUST ALLERGIES STATUS STATUS

PREVIOUS INSECT ALLERGIES STATUS STATUS

PREVIOUS BLOOD TYPE STATUS STATUS

PREVIOUS RH FACTOR STATUS STATUS

PREVIOUS HIV STATUS STATUS STATUS

PREVIOUS AIDS STATUS STATUS STATUS

PREVIOUS CANCER STATUS STATUS STATUS

PREVIOUS HEART DISEASE STATUS STATUS STATUS

PREVIOUS DIABETES STATUS STATUS STATUS

PREVIOUS HYPERTENSION STATUS STATUS STATUS

PREVIOUS ASTHMA STATUS STATUS STATUS

PREVIOUS COPD STATUS STATUS STATUS

PREVIOUS CHRONIC KIDNEY DISEASE STATUS STATUS STATUS

PREVIOUS LIVER DISEASE STATUS STATUS STATUS

PREVIOUS PANCREATITIS STATUS STATUS STATUS

PREVIOUS GALLBLADDER DISEASE STATUS STATUS STATUS

PREVIOUS APPENDICITIS STATUS STATUS STATUS

PREVIOUS DIVERTICULITIS STATUS STATUS STATUS

PREVIOUS IBS STATUS STATUS STATUS

PREVIOUS CROHN'S DISEASE STATUS STATUS STATUS

PREVIOUS ULCERS STATUS STATUS STATUS

PREVIOUS GASTRITIS STATUS STATUS STATUS

PREVIOUS GERD STATUS STATUS STATUS

PREVIOUS ACID REFLUX STATUS STATUS STATUS

PREVIOUS HEMORRHOIDS STATUS STATUS STATUS

PREVIOUS CRACKS STATUS STATUS STATUS

PREVIOUS ECZEMA STATUS STATUS STATUS

PREVIOUS PSORIASIS STATUS STATUS STATUS

PREVIOUS DERMATITIS STATUS STATUS STATUS

PREVIOUS ALLERGIES STATUS STATUS STATUS

PREVIOUS FOOD ALLERGIES STATUS STATUS STATUS

PREVIOUS DRUG ALLERGIES STATUS STATUS STATUS

PREVIOUS ENVIRONMENTAL ALLERGIES STATUS STATUS STATUS

PREVIOUS ANIMAL ALLERGIES STATUS STATUS STATUS

PREVIOUS POLLEN ALLERGIES STATUS STATUS STATUS

PREVIOUS MOLD ALLERGIES STATUS STATUS STATUS

PREVIOUS DUST ALLERGIES STATUS STATUS STATUS

PREVIOUS INSECT ALLERGIES STATUS STATUS STATUS

PREVIOUS BLOOD TYPE STATUS STATUS STATUS

PREVIOUS RH FACTOR STATUS STATUS STATUS

PREVIOUS HIV STATUS STATUS STATUS STATUS

PREVIOUS AIDS STATUS STATUS STATUS STATUS

PREVIOUS CANCER STATUS STATUS STATUS STATUS

PREVIOUS HEART DISEASE STATUS STATUS STATUS STATUS

PREVIOUS DIABETES STATUS STATUS STATUS STATUS

PREVIOUS HYPERTENSION STATUS STATUS STATUS STATUS

PREVIOUS ASTHMA STATUS STATUS STATUS STATUS

PREVIOUS COPD STATUS STATUS STATUS STATUS

PREVIOUS CHRONIC KIDNEY DISEASE STATUS STATUS STATUS STATUS

PREVIOUS LIVER DISEASE STATUS STATUS STATUS STATUS

PREVIOUS PANCREATITIS STATUS STATUS STATUS STATUS

PREVIOUS GALLBLADDER DISEASE STATUS STATUS STATUS STATUS

PREVIOUS APPENDICITIS STATUS STATUS STATUS STATUS

PREVIOUS DIVERTICULITIS STATUS STATUS STATUS STATUS

PREVIOUS IBS STATUS STATUS STATUS STATUS

PREVIOUS CROHN'S DISEASE STATUS STATUS STATUS STATUS

PREVIOUS ULCERS STATUS STATUS STATUS STATUS

PREVIOUS GASTRITIS STATUS STATUS STATUS STATUS

PREVIOUS GERD STATUS STATUS STATUS STATUS

PREVIOUS ACID REFLUX STATUS STATUS STATUS STATUS

PREVIOUS HEMORRHOIDS STATUS STATUS STATUS STATUS

PREVIOUS CRACKS STATUS STATUS STATUS STATUS

PREVIOUS ECZEMA STATUS STATUS STATUS STATUS

PREVIOUS PSORIASIS STATUS STATUS STATUS STATUS

PREVIOUS DERMATITIS STATUS STATUS STATUS STATUS

PREVIOUS ALLERGIES STATUS STATUS STATUS STATUS

PREVIOUS FOOD ALLERGIES STATUS STATUS STATUS STATUS

PREVIOUS DRUG ALLERGIES STATUS STATUS STATUS STATUS

PREVIOUS ENVIRONMENTAL ALLERGIES STATUS STATUS STATUS STATUS

PREVIOUS ANIMAL ALLERGIES STATUS STATUS STATUS STATUS

PREVIOUS POLLEN ALLERGIES STATUS STATUS STATUS STATUS

PREVIOUS MOLD ALLERGIES STATUS STATUS STATUS STATUS

PREVIOUS DUST ALLERGIES STATUS STATUS STATUS STATUS

PREVIOUS INSECT ALLERGIES STATUS STATUS STATUS STATUS

PREVIOUS BLOOD TYPE STATUS STATUS STATUS STATUS

PREVIOUS RH FACTOR STATUS STATUS STATUS STATUS

PREVIOUS HIV STATUS STATUS STATUS STATUS STATUS

PREVIOUS AIDS STATUS STATUS STATUS STATUS STATUS

PREVIOUS CANCER STATUS STATUS STATUS STATUS STATUS

PREVIOUS HEART DISEASE STATUS STATUS STATUS STATUS STATUS

PREVIOUS DIABETES STATUS STATUS STATUS STATUS STATUS

PREVIOUS HYPERTENSION STATUS STATUS STATUS STATUS STATUS

PREVIOUS ASTHMA STATUS STATUS STATUS STATUS STATUS

PREVIOUS COPD STATUS STATUS STATUS STATUS STATUS

PREVIOUS CHRONIC KIDNEY DISEASE STATUS STATUS STATUS STATUS STATUS

PREVIOUS LIVER DISEASE STATUS STATUS STATUS STATUS STATUS

PREVIOUS PANCREATITIS STATUS STATUS STATUS STATUS STATUS

PREVIOUS GALLBLADDER DISEASE STATUS STATUS STATUS STATUS STATUS

PREVIOUS APPENDICITIS STATUS STATUS STATUS STATUS STATUS

PREVIOUS DIVERTICULITIS STATUS STATUS STATUS STATUS STATUS

PREVIOUS IBS STATUS STATUS STATUS STATUS STATUS

PREVIOUS CROHN'S DISEASE STATUS STATUS STATUS STATUS STATUS

PREVIOUS ULCERS STATUS STATUS STATUS STATUS STATUS

PREVIOUS GASTRITIS STATUS STATUS STATUS STATUS STATUS

PREVIOUS GERD STATUS STATUS STATUS STATUS STATUS

PREVIOUS ACID REFLUX STATUS STATUS STATUS STATUS STATUS

PREVIOUS HEMORRHOIDS STATUS STATUS STATUS STATUS STATUS

PREVIOUS CRACKS STATUS STATUS STATUS STATUS STATUS

PREVIOUS ECZEMA STATUS STATUS STATUS STATUS STATUS

PREVIOUS PSORIASIS STATUS STATUS STATUS STATUS STATUS

PREVIOUS DERMATITIS STATUS STATUS STATUS STATUS STATUS

PREVIOUS ALLERGIES STATUS STATUS STATUS STATUS STATUS

PREVIOUS FOOD ALLERGIES STATUS STATUS STATUS STATUS STATUS

PREVIOUS DRUG ALLERGIES STATUS STATUS STATUS STATUS STATUS

PREVIOUS ENVIRONMENTAL ALLERGIES STATUS STATUS STATUS STATUS STATUS

PREVIOUS ANIMAL ALLERGIES STATUS STATUS STATUS STATUS STATUS

PREVIOUS POLLEN ALLERGIES STATUS STATUS STATUS STATUS STATUS

PREVIOUS MOLD ALLERGIES STATUS STATUS STATUS STATUS STATUS

PREVIOUS DUST ALLERGIES STATUS STATUS STATUS STATUS STATUS

PREVIOUS INSECT ALLERGIES STATUS STATUS STATUS STATUS STATUS

PREVIOUS BLOOD TYPE STATUS STATUS STATUS STATUS STATUS

PREVIOUS RH FACTOR STATUS STATUS STATUS STATUS STATUS

PREVIOUS HIV STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS AIDS STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS CANCER STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS HEART DISEASE STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS DIABETES STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS HYPERTENSION STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS ASTHMA STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS COPD STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS CHRONIC KIDNEY DISEASE STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS LIVER DISEASE STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS PANCREATITIS STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS GALLBLADDER DISEASE STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS APPENDICITIS STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS DIVERTICULITIS STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS IBS STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS CROHN'S DISEASE STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS ULCERS STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS GASTRITIS STATUS STATUS STATUS STATUS STATUS STATUS

PREVIOUS GERD STATUS STATUS STATUS STATUS STATUS STATUS

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5026 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05656

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL) HAGERSTOWN		c. LENGTH OF STAY IN lb 3YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL HANCOCK			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARLOCK MEM. CONV. HOSPITAL				d. STREET ADDRESS / HANCOCK RT. #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SUSAN Middle JANE Last HULL				4. DATE OF DEATH Month APRIL Day 25 Year 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/12/1873		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS SNYDER				14. MOTHER'S MAIDEN NAME JANE BISHOP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. THOMAS J. HULL		Address #2 HANCOCK MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO Bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH one week							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Inter trochanteric Fracture Right Femur—(Hip)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell while going to toilet.					
20c. TIME OF INJURY Hour 10:00 p.m. Month, Day, Year Nov 4 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Garlock Home		20f. (City or town) (County) (State) Hagerstown, Wash. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Edward W. Ditto III M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 4/26/60			
EXAMINER'S NAME (Type) Edward W. Ditto III, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/27/60		22c. NAME OF CEMETERY OR CREMATORY STONE BRIDGE CHUICH		22d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horne				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR APR 28 '60	
				24b. REGISTRAR'S SIGNATURE Charles L. Hume			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		1875		NEW YORK	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		NAVY	
123 Main St., Boston		Carpenter		High School		Married		None		None	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		PREVIOUS ILLNESS	
Jan 15, 1918		Home		Heart Failure		Natural		None		None	
TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		URINE	
10:00 AM		98.6		60		20		120/80		Normal	
SIGNATURE OF EXAMINER		TITLE		SIGNATURE OF WITNESS		TITLE		SIGNATURE OF DECEASED		TITLE	
[Signature]		Physician		[Signature]		Physician		[Signature]		Patient	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		PREVIOUS ILLNESS	
Jan 15, 1918		Home		Heart Failure		Natural		None		None	

7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5027

CERTIFICATE OF DEATH

05057
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 55 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		d. STREET ADDRESS 915 Hamilton Blvd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gail Elizabeth Ilgenfritz		First Middle Last		4. DATE OF DEATH April 2 19 60	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 10, 1892		9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House W ife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Chambersburg Penn.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William Colliflower		14. MOTHER'S MAIDEN NAME Mary Frederick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-32-4856		INFORMANT Howard E. Ilgenfritz Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis Heart Disease DUE TO (c) 12 years		INTERVAL BETWEEN ONSET AND DEATH 6 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic Heart Disease with Mitral Insufficiency - 60 yrs		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Nov. 1946 to April 2, 1960 , that I last saw the deceased alive on April 2, 1960 , and that death occurred at 7:00 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 998 Potomac Ave Hagerstown Md.	
ACTUAL SIGNATURE Dalton M. Welty		M.D. 998 Potomac Ave		DATE SIGNED 4-3-60	
PHYSICIAN'S NAME (Type) DALTON M. WELTY		Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-60		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
22d. LOCATION (City, town, or county) (State) Hagerstown Md.		23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR APR 5 '60		24b. REGISTRAR'S SIGNATURE Charles S. Hume			

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

Washington State Department of Health - Bureau of Vital Statistics

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
5109
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
05058

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dargan	c. LENGTH OF STAY IN 1b 65 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dargan	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Residence		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	d. STREET ADDRESS Dargan Road
3. NAME OF DECEASED (Type or print) First JESSE Middle ARNOLD Last INGRAM		4. DATE OF DEATH Month April Day 9 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 23, 1894
9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66		IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Plant	
11. BIRTHPLACE (State or foreign country) Bakerton, West Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles William Ingram		14. MOTHER'S MAIDEN NAME Annie Gertrude Welsh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-3654	
17. INFORMANT Mrs. Margaret Ingram		17. ADDRESS RFD # 1, Harpers Ferry, West Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatoid arthritis 722.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) INTERVAL BETWEEN ONSET AND DEATH 10 Years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1950 to 4/9/60 , that (I) (we) last saw the deceased alive on 4/8/60 19 7:20 AM , and that death occurred at 7:20 AM from the causes and on the date stated above.			
22a. SIGNATURE Walter H. Shealy		22b. DATE SIGNED 4/9/60	
22c. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.		22d. ADDRESS Sharpsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/12/60	23c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery	23d. LOCATION (City, town, or county) (State) Samples Manor, Md.
24. FUNERAL DIRECTOR'S SIGNATURE A. Donald Eckles		25a. REC'D BY REGISTRAR DATE APR 12 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kinne		25c. ADDRESS Harpers Ferry, West Va.	

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
DIVISION OF LABORATORY MEDICINE
WASHINGTON, D. C. 20001
CERTIFICATE OF ANALYSIS

1. Name of Patient	2. Name of Physician
3. Address	4. City
5. State	6. Zip
7. Date of Birth	8. Sex
9. Date of Admission	10. Date of Specimen Collection
11. Referring Physician	12. Referring Hospital
13. Referring Clinic	14. Referring Office
15. Referring Telephone	16. Referring Address
17. Referring City	18. Referring State
19. Referring Zip	20. Referring Country
21. Referring Hospital	22. Referring Clinic
23. Referring Office	24. Referring Telephone
25. Referring Address	26. Referring City
27. Referring State	28. Referring Zip
29. Referring Country	30. Referring Hospital
31. Referring Clinic	32. Referring Office
33. Referring Telephone	34. Referring Address
35. Referring City	36. Referring State
37. Referring Zip	38. Referring Country
39. Referring Hospital	40. Referring Clinic
41. Referring Office	42. Referring Telephone
43. Referring Address	44. Referring City
45. Referring State	46. Referring Zip
47. Referring Country	48. Referring Hospital
49. Referring Clinic	50. Referring Office
51. Referring Telephone	52. Referring Address
53. Referring City	54. Referring State
55. Referring Zip	56. Referring Country
57. Referring Hospital	58. Referring Clinic
59. Referring Office	60. Referring Telephone
61. Referring Address	62. Referring City
63. Referring State	64. Referring Zip
65. Referring Country	66. Referring Hospital
67. Referring Clinic	68. Referring Office
69. Referring Telephone	70. Referring Address
71. Referring City	72. Referring State
73. Referring Zip	74. Referring Country
75. Referring Hospital	76. Referring Clinic
77. Referring Office	78. Referring Telephone
79. Referring Address	80. Referring City
81. Referring State	82. Referring Zip
83. Referring Country	84. Referring Hospital
85. Referring Clinic	86. Referring Office
87. Referring Telephone	88. Referring Address
89. Referring City	90. Referring State
91. Referring Zip	92. Referring Country
93. Referring Hospital	94. Referring Clinic
95. Referring Office	96. Referring Telephone
97. Referring Address	98. Referring City
99. Referring State	100. Referring Zip
101. Referring Country	102. Referring Hospital
103. Referring Clinic	104. Referring Office
105. Referring Telephone	106. Referring Address
107. Referring City	108. Referring State
109. Referring Zip	110. Referring Country
111. Referring Hospital	112. Referring Clinic
113. Referring Office	114. Referring Telephone
115. Referring Address	116. Referring City
117. Referring State	118. Referring Zip
119. Referring Country	120. Referring Hospital
121. Referring Clinic	122. Referring Office
123. Referring Telephone	124. Referring Address
125. Referring City	126. Referring State
127. Referring Zip	128. Referring Country
129. Referring Hospital	130. Referring Clinic
131. Referring Office	132. Referring Telephone
133. Referring Address	134. Referring City
135. Referring State	136. Referring Zip
137. Referring Country	138. Referring Hospital
139. Referring Clinic	140. Referring Office
141. Referring Telephone	142. Referring Address
143. Referring City	144. Referring State
145. Referring Zip	146. Referring Country
147. Referring Hospital	148. Referring Clinic
149. Referring Office	150. Referring Telephone
151. Referring Address	152. Referring City
153. Referring State	154. Referring Zip
155. Referring Country	156. Referring Hospital
157. Referring Clinic	158. Referring Office
159. Referring Telephone	160. Referring Address
161. Referring City	162. Referring State
163. Referring Zip	164. Referring Country
165. Referring Hospital	166. Referring Clinic
167. Referring Office	168. Referring Telephone
169. Referring Address	170. Referring City
171. Referring State	172. Referring Zip
173. Referring Country	174. Referring Hospital
175. Referring Clinic	176. Referring Office
177. Referring Telephone	178. Referring Address
179. Referring City	180. Referring State
181. Referring Zip	182. Referring Country
183. Referring Hospital	184. Referring Clinic
185. Referring Office	186. Referring Telephone
187. Referring Address	188. Referring City
189. Referring State	190. Referring Zip
191. Referring Country	192. Referring Hospital
193. Referring Clinic	194. Referring Office
195. Referring Telephone	196. Referring Address
197. Referring City	198. Referring State
199. Referring Zip	200. Referring Country

ANALYSIS OF SPECIMEN NO. 1234567890
DATE OF ANALYSIS: 12/15/78
ANALYST: J. H. SMITH
REMARKS: Specimen received from Dr. J. H. Smith, M.D.,
1234 Main St., Anytown, U.S.A. 12345. Specimen
consisted of 10 ml. of blood, 5 ml. of urine, and 5 ml.
of feces. All specimens were analyzed and found to be
negative for all substances tested. No further action
is recommended.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5028 CERTIFICATE OF DEATH

05059
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 5 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle LOUISE Last IRVIN		4. DATE OF DEATH Month April Day 4 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8 1890
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Paulsgrove		14. MOTHER'S MAIDEN NAME Sarah Hose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Jos M. Irvin Hagerstown Md. R # 4		Address Greencastle Pike	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 493X DUE TO Renal shutdown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Pneumonia + Congestive Heart Failure (b) 3dys (c) 3dys PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cachexia		INTERVAL BETWEEN ONSET AND DEATH 3dys 3dys 4dys	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1959 to April 4 1960 that (I) (we) last saw the deceased alive on April 4 1960 and that death occurred at PM , from the causes and on the date stated above.			
22a. SIGNATURE M. E. Byrkit		22b. DATE SIGNED 4-5-60	
22c. PHYSICIAN'S NAME (Type) M. E. Byrkit		22d. ADDRESS 28 W Potomac Wharf Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr 7 1960	
23c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery		23d. LOCATION (City, town, or county) (State) near Clear Spring Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		25a. REC'D BY REGISTRAR DATE APR 7 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

THE BUREAU OF DEATH

5022

CO.

CO.

CO.

5 days

5 days

Discharge

Discharge

April 8 1900

April 8 1900

April 8 1900

April 8 1900

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

Discharge

CERTIFICATE OF DEATH

Reg. Dist. No. 05060

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RT 1 Clear Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural RT 1.</u>		d. STREET ADDRESS <u>RT 2</u>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Keefe</u> Middle <u>R</u> Last <u>R</u>		4. DATE OF DEATH <u>April</u> Month <u>19</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR <u>6</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Isaac Keefe</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hedy Cutchall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Carl Keefe</u> Address <u>RT 2 Greencastle, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO <u>Arterio Sclerotic Heart Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 yrs.</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Marked Inguinal Hernia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>Mar</u> Day <u>20</u> Year <u>1960</u> Hour <u>19</u> o. m. <u>p. m.</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 20, 1960</u> to <u>April 19, 1960</u> , that I last saw the deceased alive on <u>April 18, 1960</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>4/20/60</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BRETHREN CH. CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>HANCOCK, Md. P. Y</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Th. L. Linger</u> ADDRESS <u>Merersburg, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 22 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove rubber papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5029

CERTIFICATE OF DEATH

05061

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 708 W. Franklin St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle STANLEY Last KETTERMAN		4. DATE OF DEATH Month April Day 4 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1888
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 7 Days 15 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Board of Education	
11. BIRTHPLACE (State or foreign country) Pen Mar, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Ketterman		14. MOTHER'S MAIDEN NAME Mary Sherman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-09-3199	
17. INFORMANT Mrs. C.S. Ketterman		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH April 2, 1960		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12, 1958 to April 4, 1960 that I last saw the deceased alive on April 4, 1960 and that death occurred at 3 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sidney Novenstein		ADDRESS (Street, city or town, state) 2 N. ... Md.	
PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN		DATE SIGNED 4-4-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/60	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. REGISTRAR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE APR 6 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7029

CERTIFICATE OF DEATH

100-100000

Registration

Section

Registration

Registration

100-100000

100-100000

CHARLES

CHARLES

April

White

Oct. 7, 1980

Location

Board of Registration

State Registrar

State Registrar

100-100000

100-100000

Charles

Charles

Charles

Charles

Charles

Charles

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 18 Film 262 5-6-60 ans									
5030 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 05063									
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WASH.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 21-03-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1108 CARROLL HEIGHTS BLVD.					d. STREET ADDRESS 1108 CARROLL HEIGHTS BLVD.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE E. KNOTT					4. DATE OF DEATH Month Day Year 4 8 1960				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 13, 1915		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRUG ISMAN			10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN C. KNOTT					14. MOTHER'S MAIDEN NAME CLARINE DUFFY				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-16-1941		17. INFORMANT Address MRS. MARGARET KNOTT HAGERSTOWN, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 353.3 Aspiration of Vomitus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Epilepsy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>[Signature]</i> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) FRED W. KNAISS					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 4/9/60				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/11/1960		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL		22d. LOCATION (City, town, or county) (State) HAGERSTOWN, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE FRED W. KNAISS HAGERSTOWN, MD.					24a. REC'D BY REGISTRAR DATE APR 12 '60		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

1
5031
MARDLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
05064

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Turner Middle P. Last Luttrell				4. DATE OF DEATH Month 4 Day 29 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-1876		9. AGE (In years last birthday) yrs. 84	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.Co.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard H. Luttrell				14. MOTHER'S MAIDEN NAME Eliza Jane Lawyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-12-1907		17. INFORMANT Address Mrs. Victoria Hovermale, Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure						INTERVAL BETWEEN ONSET AND DEATH 3 Days.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-25-1960 to 4-29-1960 , that (I) (we) last saw the deceased alive on 4-28-1960 , and that death occurred at 6:04 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Secondari				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOSEPH SECONDARI				22d. ADDRESS Boonesboro, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-5-1960		23c. NAME OF CEMETERY OR CREMATORY Park Heights		23d. LOCATION (City, town, or county) (State) Brunswick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE B. H. Felle				25a. REC'D BY REGISTRAR DATE MAY 3 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

5093

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05065

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				c. LENGTH OF STAY IN 1b X Williamsport			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 25 S. Vermont Street				e. STREET ADDRESS 25 S. Vermont Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAZIE Middle MAY Last MARKER				4. DATE OF DEATH Month April Day 12 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 13, 1918	
9. AGE (In years lost birthday) 41 yrs.		10. IF UNDER 1 YEAR Months 41 Days 12 Hours 19 Min. 60		11. BIRTHPLACE (State or foreign country) Williamsport District, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Alva J. Lamp				14. MOTHER'S MAIDEN NAME Rose M. Fowler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT R. Ponytz Marker Williamsport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction (presumptive) 420.1 DUE TO Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) about 4 years DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic Heart Disease, inactive INTERVAL BETWEEN ONSET AND DEATH about 4 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 10-16, 1957 to 4-12, 1960 , that (I) (we) last saw the deceased alive on 3/25, 1960 , and that death occurred at 9:15 AM on the causes and on the date stated above.							
22a. SIGNATURE John H. Hornbaker				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.				22d. ADDRESS 154 West Washington St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/16/1960		23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Williamsport, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home R. Franklin Meyer				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE APR 18 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Huns							

125085

DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS AND STATISTICS

CERTIFICATE OF DEATH

2013

420.1

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5032

CERTIFICATE OF DEATH

Reg. Dist. No.

05066

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Smithsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				1d. STREET ADDRESS <u>Smithsburg #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Noomi</u> First <u>Cynthia</u> Middle <u>MARKER</u> Last				4. DATE OF DEATH <u>April</u> Month <u>10</u> Day <u>19</u> Year <u>60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/4/1902</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Duties</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Reed Md.</u>	
13. FATHER'S NAME <u>Charles E. Marker</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Harshman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-36-6972</u>		17. INFORMANT <u>Miss Edith M. Marker, Smithsburg Md., #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTERMURAL HEMORRHAGE, left CORONARY ARTERY</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>10 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS OBESITY</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE/HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 6</u> , 19 <u>60</u> , to <u>April 10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 9</u> , 19 <u>60</u> , and that death occurred at <u>8:45</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. R. Landry</u>				ADDRESS (Street, city or town, state) <u>12 South Main St Smithsburg Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. R. Landry</u>				DATE SIGNED <u>4-10-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Washington, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter G. Hove, Waynesboro Pa.</u>				ADDRESS <u>Waynesboro Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 12 60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

5094

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>4 yrs 5 mos 18 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1 Route #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Amie</u> Middle <u>Martin</u> Last <u>Martin</u>			4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 29 1883</u>	9. AGE (In years lost birthday) <u>77</u> yrs.	10. IF UNDER 1 YEAR Months <u>3</u> Days <u>7</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Leitersburg</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			13. FATHER'S NAME <u>Joseph Martin</u>				
14. MOTHER'S MAIDEN NAME <u>Margaret Clopper</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT Address <u>Mrs. Marion Hartle Williamsport Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO <u>5 yrs</u> (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour a. m. <u></u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>Aug 1 1960</u> to <u>April 28 1960</u> that I last saw the deceased alive on <u>April 27 1960</u> , and that death occurred at <u>7:50</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M.E. Byrkit</u>		ADDRESS (Street, city or town, state) <u>28 W Potomac</u> DATE SIGNED <u>4-28-60</u>					
PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		M.D. <u>Williamsport Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 1-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Leitersburg Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Leitersburg Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport Md.</u>		ADDRESS <u></u>		24a. REC'D BY REGISTRAR DATE <u>MAY 2 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		

TABLE 2

STO

9th Edition

Q. I am.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05068

5033

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 1240 Glenwood Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First J Middle Howard Last McCune		4. DATE OF DEATH Month 4 Day 21 Year 19 60						
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1885	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Printer		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Thomas McCune			14. MOTHER'S MAIDEN NAME Mary E. Atherton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-09-7827		17. INFORMANT John McCune Address 314 Radcliff Ave., City				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete heart block, recurrent DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Posterior septal myocardial infarction DUE TO (c) arteriosclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH moments 12 days years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Resolving left lower lobe pneumonia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/9 19 60 to 4/21 19 60 , that (I) (we) last saw the deceased alive on 4/20 19 60 , and that death occurred at 8AM , from the causes and on the date stated above.								
22a. SIGNATURE John C. Stauffer				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4-23-60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill		23d. LOCATION (City, town, or county) Hagerstown (State) Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss ADDRESS Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE APR 25 '60		25b. REGISTRAR'S SIGNATURE Arthur S. House		

45088

CERTIFICATE OF DEATH

45088



Washington

10 days

in State

Wash. Co. Hospital

1210 Lincoln Ave.

Wash. Co. Hospital

June 30, 1931

11 days

in State

John Thomas Rogers

Mary B. Rogers

11-0-1931

John Rogers 314 Webster Ave. City



11-11-31

Home Mail

Washington

Prob. B. Rogers Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
5034
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5034
CERTIFICATE OF DEATH

05069

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 6Wks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPH ELMER McDANIEL				4. DATE OF DEATH April 23 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 6, 1876	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		11. BIRTHPLACE (State or foreign country) Everett Bedfore Co, Pa	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Willson W. McDaniel		14. MOTHER'S MAIDEN NAME Adeline Leader		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Vera H. McDaniel		Address 816 Virginia Ave		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] Hagerstown Md.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Arterio sclerotic DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 Wks 1 year		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 14 March to 24 April 19 60 , that (I) (we) last saw the deceased alive on 23 April 19 60 , and that death occurred at 11 PM , from the causes and on the date stated above.		22a. SIGNATURE Edwin S Hoachlorn M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 4/25/60	
22c. PHYSICIAN'S NAME (Type) Edwin S Hoachlorn		22d. ADDRESS Hagerstown Md		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/60	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md		24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR APR 28 '60	
25b. REGISTRAR'S SIGNATURE Christina S. Kneass		25c. DATE APR 28 '60		25d. ADDRESS Hagerstown Md.		25e. SIGNATURE Christina S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05070

5035

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PA</u> b. COUNTY <u>Fulton</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u> <u>75X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wayne</u> Middle <u>Woodford</u> Last <u>Mellott</u>			4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 12 1892</u>		9. AGE (In years lost birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anderson Mellott</u>				14. MOTHER'S MAIDEN NAME <u>Ida Mae Shives</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs Catherine Mellott Warfordburg PA</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Hypertensive heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>60</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 18, 1960</u> to <u>April 26, 1960</u> , that I last saw the deceased alive on <u>April 26, 1960</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John C. Stauffer</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-29-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Needmore Fulton Co, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Sipes</u>				ADDRESS <u>Harrisonville Pa</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. K...</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R#2		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hagerstown R#2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle ARBENA Last MILLER		4. DATE OF DEATH Month April Day 16 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1894
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Eccard, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hiram Hoffman		14. MOTHER'S MAIDEN NAME Susan Reese	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT Mr. Thomas A. Miller R#2 Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio-sclerotic Heart D. (c) pericarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval BETWEEN ONSET AND DEATH 3 weeks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 24th , 19 60 , to April 16 , 19 60 , that I last saw the deceased alive on April 16 , 19 60 , and that death occurred at 8 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 4-16-60			
ACTUAL SIGNATURE SIDNEY NOVENSTEIN		PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/18/60	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		ADDRESS 4-16-60	
24a. REC'D BY REGISTRAR APR 19 60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

428.0

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5112
CERTIFICATE OF DEATH

05072

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md RFD #1				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Downsville				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annie Middle Orea Last Moats				4. DATE OF DEATH Month April Day 12 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11 1881	
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR 10 Months 1 Days		11. IF UNDER 24 HRS. 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Bakersville Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Thomas A. Wolford				14. MOTHER'S MAIDEN NAME Ann Elizabeth Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. George Moats		Address Williamsport Md RFD #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental suffocation 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Day							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/12/60 19 to 4/12/60 19, that (I) (we) last saw the deceased alive on 4/12/60 19, and that death occurred 4/12/60 19 from the causes and on the date stated above.							
22a. SIGNATURE Joseph Young				22b. DATE SIGNED 4/12/60		22c. PHYSICIAN'S NAME (Type) Williamsport Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 14-60		23c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery		23d. LOCATION (City, town, or county) (State) Bakersville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edith V. Leaf				25a. REC'D BY REGISTRAR William sport Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

05032

COMMUNAL STATE OF DEATH

2112

4

?

Washington

Washington

Washington

Local Affairs Bureau No. 100

Local Affairs Bureau No. 100

Domestic Affairs

Domestic Affairs

Gray, Thomas

Gray, Thomas

1912

1912

May 11 1912

May 11 1912

Domestic Affairs

Domestic Affairs

Domestic Affairs

Domestic Affairs

Domestic Affairs

Domestic Affairs

Domestic Affairs

Domestic Affairs

Domestic Affairs

Domestic Affairs

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

115073

5113

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHARPSBURG</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ALONG ROUTE 34</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BEAVER CREEK - RURAL</u> d. STREET ADDRESS <u>HAGERSTOWN MD. R.I.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>George McClelland Mowen</u>		4. DATE OF DEATH Month Day Year <u>APRIL - 17 - 19 60</u>							
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 13. 1931</u>						
9. AGE (In years last birthday) <u>28</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> <tr> <td><u>7</u> <u>4</u></td> <td><u> </u> <u> </u></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	<u>7</u> <u>4</u>	<u> </u> <u> </u>	10. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months Days	Hours Min.								
<u>7</u> <u>4</u>	<u> </u> <u> </u>								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER - BOWDERS AND SELLERS ABBITOR.</u>		11. BIRTHPLACE (State or foreign country) <u>FRANKLIN CO. PENNA.</u>							
13. FATHER'S NAME <u>MARVIN MOWEN</u>		14. MOTHER'S MAIDEN NAME <u>HAZEL STINE</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>168-24-2611</u>							
17. INFORMANT <u>MRS. PATSY MOWEN</u>		Address <u>HAGERSTOWN MD R.I.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Amputation Left Leg Above Knee.</u> DUE TO (c) <u>Fracture Right Humerus & Femur</u> </td> <td> INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> </td> </tr> </table>				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Amputation Left Leg Above Knee.</u> DUE TO (c) <u>Fracture Right Humerus & Femur</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Amputation Left Leg Above Knee.</u> DUE TO (c) <u>Fracture Right Humerus & Femur</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Speeding car left road crashing into tree.</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>9:47</u> p. m. <u>4-17-</u> <u>1960</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State R # 34</u>		20f. (City or town) (County) (State) <u>Sharpsburg, Wash. Md.</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>A. E. Ditto</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-19-60</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR. 22. 1960</u>							
22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>		ADDRESS <u>BOONSBORO MD</u>							
24a. REC'D BY REGISTRAR <u>APR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5036
CERTIFICATE OF DEATH

05074

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WASH.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSP.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XCAVETOWN	
3. NAME OF DECEASED (Type or print) First HERMAN Middle F. Last MUNSON		4. DATE OF DEATH Month 4 Day 7 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 15, 1881
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY GEN CONTRACTING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERICK MUNSON		14. MOTHER'S MAIDEN NAME AMELIA SHAFER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-4919	
17. INFORMANT MRS. STELLA MUNSON		Address CAVETOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Caecum 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized metastases (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 mo. 1 mo. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-13 19 57 to 4-7 19 60 , that (I) (we) last saw the deceased alive on 4-7 19 60 , and that death occurred on 10^{PM} from the causes and on the date stated above.			
22a. SIGNATURE Charles F. Hess		22b. DATE 4-9-60	
22c. PHYSICIAN'S NAME (Type) Smithsburg, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/11/1960	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL		23d. LOCATION (City, town, or county) (State) HAGERSTOWN, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS		25a. REC'D BY REGISTRAR DATE APR 12 '60	
ADDRESS HAGERSTOWN, MD.		25b. REGISTRAR'S SIGNATURE Charles S. Hesse	

05074

MARYLAND STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

7056

20

7-4

72

21-21

20

7-4

5114
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pa. b. COUNTY Franklin				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Ringgold			c. LENGTH OF STAY IN 1b 2 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Waynesboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hagerstown #5				X d. STREET ADDRESS 140 S. Broad St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Susan Middle Pauline Last Neady				4. DATE OF DEATH Month April Day 13 Year 60				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1891		
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Upton Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Neady				14. MOTHER'S MAIDEN NAME Charlotte Speilman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. S. Harold Martin, Waynesboro, Pa.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon 153.8 DUE TO with generalized metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
				20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that I attended the deceased from 3/15/ 19 56 , to 4/13 19 60 , that I last saw the deceased alive on 4/13 19 60 , and that death occurred at 8:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1 West Main Street Waynesboro, Pennsylvania DATE SIGNED _____								
ACTUAL SIGNATURE C. W. Lindeman M.D.								
PHYSICIAN'S NAME (Type) C. W. Lindeman, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/60		22c. NAME OF CEMETERY OR CREMATORY Green Hill		22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Co., Pa.		
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Spang Waynesboro Pa				ADDRESS		24a. REC'D BY REGISTRAR DATE APR 18 '60		
				24b. REGISTRAR'S SIGNATURE Arthur S. [Signature]				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled out by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

153.8

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth	
6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician	
11. Signature of registrar		12. Signature of informant		13. Signature of medical examiner		14. Signature of coroner		15. Signature of jury	
16. Signature of funeral director		17. Signature of undertaker		18. Signature of cemetery		19. Signature of burial place		20. Signature of interment	
21. Signature of burial place		22. Signature of interment		23. Signature of burial place		24. Signature of interment		25. Signature of burial place	
26. Signature of interment		27. Signature of burial place		28. Signature of interment		29. Signature of burial place		30. Signature of interment	
31. Signature of burial place		32. Signature of interment		33. Signature of burial place		34. Signature of interment		35. Signature of burial place	
36. Signature of interment		37. Signature of burial place		38. Signature of interment		39. Signature of burial place		40. Signature of interment	
41. Signature of burial place		42. Signature of interment		43. Signature of burial place		44. Signature of interment		45. Signature of burial place	
46. Signature of interment		47. Signature of burial place		48. Signature of interment		49. Signature of burial place		50. Signature of interment	
51. Signature of burial place		52. Signature of interment		53. Signature of burial place		54. Signature of interment		55. Signature of burial place	
56. Signature of interment		57. Signature of burial place		58. Signature of interment		59. Signature of burial place		60. Signature of interment	
61. Signature of burial place		62. Signature of interment		63. Signature of burial place		64. Signature of interment		65. Signature of burial place	
66. Signature of interment		67. Signature of burial place		68. Signature of interment		69. Signature of burial place		70. Signature of interment	
71. Signature of burial place		72. Signature of interment		73. Signature of burial place		74. Signature of interment		75. Signature of burial place	
76. Signature of interment		77. Signature of burial place		78. Signature of interment		79. Signature of burial place		80. Signature of interment	
81. Signature of burial place		82. Signature of interment		83. Signature of burial place		84. Signature of interment		85. Signature of burial place	
86. Signature of interment		87. Signature of burial place		88. Signature of interment		89. Signature of burial place		90. Signature of interment	
91. Signature of burial place		92. Signature of interment		93. Signature of burial place		94. Signature of interment		95. Signature of burial place	
96. Signature of interment		97. Signature of burial place		98. Signature of interment		99. Signature of burial place		100. Signature of interment	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00000
5115 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05076
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring Md.	c. LENGTH OF STAY IN 1b 10 Minutes	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charmian 75x 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Paul Middle C. Last Niemyer		4. DATE OF DEATH Month April Day 10 Year 1960	

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/1897	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cost Accountant		10b. KIND OF BUSINESS OR INDUSTRY Funkhouser Plant		11. BIRTHPLACE (State or foreign country) Green Spring Furnace Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William G. Niemyer	14. MOTHER'S MAIDEN NAME Myrtie Tedrick
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War 1	16. SOCIAL SECURITY NO. 214-09-1337
17. INFORMANT Mrs. Paul C. Niemyer, Charmian, Pa.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) arterio-sclerotic heart disease (c) 2 yrs DUE TO		INTERVAL BETWEEN ONSET AND DEATH instant
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-----------------------------------------------------------------------------------------------------------------------------------	--	---------------------------------------------------------------------------------------------------

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE DREW H. TITZ M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 4/10/60
EXAMINER'S NAME (Type) DREW H. TITZ	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/12/60	22c. NAME OF CEMETERY OR CREMATORY St. Paul Lutheran	22d. LOCATION (City, town, or county) (State) Clear Spring, Washington Co. Md.
------------------------------------------------------------	-------------------------------------	----------------------------------------------------------------	------------------------------------------------------------------------------------------

23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Goss	ADDRESS Waynesboro Pa.	24a. REC'D BY REGISTRAR DATE APR 12 '60	24b. REGISTRAR'S SIGNATURE William S. Huns
-----------------------------------------------------------	----------------------------------	---------------------------------------------------	------------------------------------------------------

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

05096

STATE OF CALIFORNIA DEPARTMENT OF HEALTH—BUREAU OF VITAL STATISTICS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. OCCUPATION [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. DATE OF DEATH [REDACTED]</p>	
<p>7. TIME OF DEATH [REDACTED]</p>		<p>8. PLACE OF DEATH [REDACTED]</p>	
<p>9. CAUSE OF DEATH [REDACTED]</p>		<p>10. MANNER OF DEATH [REDACTED]</p>	
<p>11. SIGNATURE OF MEDICAL EXAMINER [REDACTED]</p>		<p>12. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS [REDACTED]</p>		<p>14. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>15. SIGNATURE OF WITNESS [REDACTED]</p>		<p>16. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>17. SIGNATURE OF WITNESS [REDACTED]</p>		<p>18. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>19. SIGNATURE OF WITNESS [REDACTED]</p>		<p>20. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>21. SIGNATURE OF WITNESS [REDACTED]</p>		<p>22. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>23. SIGNATURE OF WITNESS [REDACTED]</p>		<p>24. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>25. SIGNATURE OF WITNESS [REDACTED]</p>		<p>26. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>27. SIGNATURE OF WITNESS [REDACTED]</p>		<p>28. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>29. SIGNATURE OF WITNESS [REDACTED]</p>		<p>30. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>31. SIGNATURE OF WITNESS [REDACTED]</p>		<p>32. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>33. SIGNATURE OF WITNESS [REDACTED]</p>		<p>34. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>35. SIGNATURE OF WITNESS [REDACTED]</p>		<p>36. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>37. SIGNATURE OF WITNESS [REDACTED]</p>		<p>38. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>39. SIGNATURE OF WITNESS [REDACTED]</p>		<p>40. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>41. SIGNATURE OF WITNESS [REDACTED]</p>		<p>42. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>43. SIGNATURE OF WITNESS [REDACTED]</p>		<p>44. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>45. SIGNATURE OF WITNESS [REDACTED]</p>		<p>46. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>47. SIGNATURE OF WITNESS [REDACTED]</p>		<p>48. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>49. SIGNATURE OF WITNESS [REDACTED]</p>		<p>50. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>51. SIGNATURE OF WITNESS [REDACTED]</p>		<p>52. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>53. SIGNATURE OF WITNESS [REDACTED]</p>		<p>54. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>55. SIGNATURE OF WITNESS [REDACTED]</p>		<p>56. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>57. SIGNATURE OF WITNESS [REDACTED]</p>		<p>58. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>59. SIGNATURE OF WITNESS [REDACTED]</p>		<p>60. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>61. SIGNATURE OF WITNESS [REDACTED]</p>		<p>62. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>63. SIGNATURE OF WITNESS [REDACTED]</p>		<p>64. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>65. SIGNATURE OF WITNESS [REDACTED]</p>		<p>66. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>67. SIGNATURE OF WITNESS [REDACTED]</p>		<p>68. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>69. SIGNATURE OF WITNESS [REDACTED]</p>		<p>70. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>71. SIGNATURE OF WITNESS [REDACTED]</p>		<p>72. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>73. SIGNATURE OF WITNESS [REDACTED]</p>		<p>74. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>75. SIGNATURE OF WITNESS [REDACTED]</p>		<p>76. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>77. SIGNATURE OF WITNESS [REDACTED]</p>		<p>78. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>79. SIGNATURE OF WITNESS [REDACTED]</p>		<p>80. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>81. SIGNATURE OF WITNESS [REDACTED]</p>		<p>82. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>83. SIGNATURE OF WITNESS [REDACTED]</p>		<p>84. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>85. SIGNATURE OF WITNESS [REDACTED]</p>		<p>86. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>87. SIGNATURE OF WITNESS [REDACTED]</p>		<p>88. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>89. SIGNATURE OF WITNESS [REDACTED]</p>		<p>90. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>91. SIGNATURE OF WITNESS [REDACTED]</p>		<p>92. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>93. SIGNATURE OF WITNESS [REDACTED]</p>		<p>94. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>95. SIGNATURE OF WITNESS [REDACTED]</p>		<p>96. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>97. SIGNATURE OF WITNESS [REDACTED]</p>		<p>98. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>99. SIGNATURE OF WITNESS [REDACTED]</p>		<p>100. SIGNATURE OF DECEASED [REDACTED]</p>	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05077

Reg. Dist. No.

5037

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY WASH.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	c. LENGTH OF STAY IN 1b 4 HOURS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CLEAR SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FAIRCHILD AIRCRAFT PLANT I		e. STREET ADDRESS MILL ST.	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last VIRGIL B. PECK		4. DATE OF DEATH Month Day Year 4 21 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCT 15, 1904
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOBE PECK	
14. MOTHER'S MAIDEN NAME NORA SUFFECOL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 220-09-9297		17. INFORMANT MRS. JAMES COYLE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (b) General arteriosclerosis & (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH TWO WEEKS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/23/1960	
22c. NAME OF CEMETERY OR CREMATORY BLAIRS VALLEY		22d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. CLARK		24b. REGISTRAR'S SIGNATURE Arthur S. Thacker	
24c. REC'D BY REGISTRAR DATE APR 25 '60		24d. REGISTRAR'S SIGNATURE	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 70
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: JOHN J. BROWN

2. SEX: Male

3. AGE: 45

4. DATE OF BIRTH: 1910

5. PLACE OF BIRTH: NEW YORK

6. OCCUPATION: Engineer

7. MARITAL STATUS: Married

8. EDUCATION: High School

9. RELIGION: Catholic

10. RACE: White

11. COLOR: White

12. HEIGHT: 5' 8"

13. WEIGHT: 175

14. BUILD: Medium

15. HAIR: Brown

16. EYES: Blue

17. SKIN: Fair

18. TONGUE: Normal

19. THROAT: Normal

20. LUNGS: Normal

21. HEART: Normal

22. LIVER: Normal

23. SPLEEN: Normal

24. PANCREAS: Normal

25. STOMACH: Normal

26. SMALL INTESTINE: Normal

27. LARGE INTESTINE: Normal

28. RECTUM: Normal

29. UTERUS: Normal

30. VAGINA: Normal

31. CERVIX: Normal

32. VULVA: Normal

33. CLITORIS: Normal

34. LABIA: Normal

35. PERINEUM: Normal

36. ANUS: Normal

37. PENIS: Normal

38. TESTES: Normal

39. PROSTATE: Normal

40. BLADDER: Normal

41. URETERS: Normal

42. KIDNEYS: Normal

43. ADRENALS: Normal

44. THYROID: Normal

45. PARATHYROID: Normal

46. PITUITARY: Normal

47. HYPOTHALAMUS: Normal

48. HYPHYPHYS: Normal

49. SPINAL CORD: Normal

50. BRAIN: Normal

51. EYES: Normal

52. EARS: Normal

53. NOSE: Normal

54. MOUTH: Normal

55. PHARYNX: Normal

56. LARYNX: Normal

57. TRACHEA: Normal

58. BRONCHI: Normal

59. LUNGS: Normal

60. PLEURA: Normal

61. PERICARDIUM: Normal

62. HEART: Normal

63. CORONARY ARTERIES: Normal

64. AORTA: Normal

65. PULMONARY ARTERY: Normal

66. PULMONARY VEIN: Normal

67. VESSELS: Normal

68. CAPILLARIES: Normal

69. LYMPHATIC SYSTEM: Normal

70. BLOOD: Normal

71. URINE: Normal

72. FECES: Normal

73. SWEAT: Normal

74. SALIVA: Normal

75. TEARS: Normal

76. MUCUS: Normal

77. CEREBROSPINAL FLUID: Normal

78. SPINAL FLUID: Normal

79. JOINTS: Normal

80. BONES: Normal

81. MUSCLES: Normal

82. NERVES: Normal

83. GLANDS: Normal

84. SKIN: Normal

85. NAILS: Normal

86. HAIR: Normal

87. EYES: Normal

88. EARS: Normal

89. NOSE: Normal

90. MOUTH: Normal

91. PHARYNX: Normal

92. LARYNX: Normal

93. TRACHEA: Normal

94. BRONCHI: Normal

95. LUNGS: Normal

96. PLEURA: Normal

97. PERICARDIUM: Normal

98. HEART: Normal

99. CORONARY ARTERIES: Normal

100. AORTA: Normal

101. PULMONARY ARTERY: Normal

102. PULMONARY VEIN: Normal

103. VESSELS: Normal

104. CAPILLARIES: Normal

105. LYMPHATIC SYSTEM: Normal

106. BLOOD: Normal

107. URINE: Normal

108. FECES: Normal

109. SWEAT: Normal

110. SALIVA: Normal

111. TEARS: Normal

112. MUCUS: Normal

113. CEREBROSPINAL FLUID: Normal

114. SPINAL FLUID: Normal

115. JOINTS: Normal

116. BONES: Normal

117. MUSCLES: Normal

118. NERVES: Normal

119. GLANDS: Normal

120. SKIN: Normal

121. NAILS: Normal

122. HAIR: Normal

123. EYES: Normal

124. EARS: Normal

125. NOSE: Normal

126. MOUTH: Normal

127. PHARYNX: Normal

128. LARYNX: Normal

129. TRACHEA: Normal

130. BRONCHI: Normal

131. LUNGS: Normal

132. PLEURA: Normal

133. PERICARDIUM: Normal

134. HEART: Normal

135. CORONARY ARTERIES: Normal

136. AORTA: Normal

137. PULMONARY ARTERY: Normal

138. PULMONARY VEIN: Normal

139. VESSELS: Normal

140. CAPILLARIES: Normal

141. LYMPHATIC SYSTEM: Normal

142. BLOOD: Normal

143. URINE: Normal

144. FECES: Normal

145. SWEAT: Normal

146. SALIVA: Normal

147. TEARS: Normal

148. MUCUS: Normal

149. CEREBROSPINAL FLUID: Normal

150. SPINAL FLUID: Normal

151. JOINTS: Normal

152. BONES: Normal

153. MUSCLES: Normal

154. NERVES: Normal

155. GLANDS: Normal

156. SKIN: Normal

157. NAILS: Normal

158. HAIR: Normal

159. EYES: Normal

160. EARS: Normal

161. NOSE: Normal

162. MOUTH: Normal

163. PHARYNX: Normal

164. LARYNX: Normal

165. TRACHEA: Normal

166. BRONCHI: Normal

167. LUNGS: Normal

168. PLEURA: Normal

169. PERICARDIUM: Normal

170. HEART: Normal

171. CORONARY ARTERIES: Normal

172. AORTA: Normal

173. PULMONARY ARTERY: Normal

174. PULMONARY VEIN: Normal

175. VESSELS: Normal

176. CAPILLARIES: Normal

177. LYMPHATIC SYSTEM: Normal

178. BLOOD: Normal

179. URINE: Normal

180. FECES: Normal

181. SWEAT: Normal

182. SALIVA: Normal

183. TEARS: Normal

184. MUCUS: Normal

185. CEREBROSPINAL FLUID: Normal

186. SPINAL FLUID: Normal

187. JOINTS: Normal

188. BONES: Normal

189. MUSCLES: Normal

190. NERVES: Normal

191. GLANDS: Normal

192. SKIN: Normal

193. NAILS: Normal

194. HAIR: Normal

195. EYES: Normal

196. EARS: Normal

197. NOSE: Normal

198. MOUTH: Normal

199. PHARYNX: Normal

200. LARYNX: Normal

201. TRACHEA: Normal

202. BRONCHI: Normal

203. LUNGS: Normal

204. PLEURA: Normal

205. PERICARDIUM: Normal

206. HEART: Normal

207. CORONARY ARTERIES: Normal

208. AORTA: Normal

209. PULMONARY ARTERY: Normal

210. PULMONARY VEIN: Normal

211. VESSELS: Normal

212. CAPILLARIES: Normal

213. LYMPHATIC SYSTEM: Normal

214. BLOOD: Normal

215. URINE: Normal

216. FECES: Normal

217. SWEAT: Normal

218. SALIVA: Normal

219. TEARS: Normal

220. MUCUS: Normal

221. CEREBROSPINAL FLUID: Normal

222. SPINAL FLUID: Normal

223. JOINTS: Normal

224. BONES: Normal

225. MUSCLES: Normal

226. NERVES: Normal

227. GLANDS: Normal

228. SKIN: Normal

229. NAILS: Normal

230. HAIR: Normal

231. EYES: Normal

232. EARS: Normal

233. NOSE: Normal

234. MOUTH: Normal

235. PHARYNX: Normal

236. LARYNX: Normal

237. TRACHEA: Normal

238. BRONCHI: Normal

239. LUNGS: Normal

240. PLEURA: Normal

241. PERICARDIUM: Normal

242. HEART: Normal

243. CORONARY ARTERIES: Normal

244. AORTA: Normal

245. PULMONARY ARTERY: Normal

246. PULMONARY VEIN: Normal

247. VESSELS: Normal

248. CAPILLARIES: Normal

249. LYMPHATIC SYSTEM: Normal

250. BLOOD: Normal

251. URINE: Normal

252. FECES: Normal

253. SWEAT: Normal

254. SALIVA: Normal

255. TEARS: Normal

256. MUCUS: Normal

257. CEREBROSPINAL FLUID: Normal

258. SPINAL FLUID: Normal

259. JOINTS: Normal

260. BONES: Normal

261. MUSCLES: Normal

262. NERVES: Normal

263. GLANDS: Normal

264. SKIN: Normal

265. NAILS: Normal

266. HAIR: Normal

267. EYES: Normal

268. EARS: Normal

269. NOSE: Normal

270. MOUTH: Normal

271. PHARYNX: Normal

272. LARYNX: Normal

273. TRACHEA: Normal

274. BRONCHI: Normal

275. LUNGS: Normal

276. PLEURA: Normal

277. PERICARDIUM: Normal

278. HEART: Normal

279. CORONARY ARTERIES: Normal

280. AORTA: Normal

281. PULMONARY ARTERY: Normal

282. PULMONARY VEIN: Normal

283. VESSELS: Normal

284. CAPILLARIES: Normal

285. LYMPHATIC SYSTEM: Normal

286. BLOOD: Normal

287. URINE: Normal

288. FECES: Normal

289. SWEAT: Normal

290. SALIVA: Normal

291. TEARS: Normal

292. MUCUS: Normal

293. CEREBROSPINAL FLUID: Normal

294. SPINAL FLUID: Normal

295. JOINTS: Normal

296. BONES: Normal

297. MUSCLES: Normal

298. NERVES: Normal

299. GLANDS: Normal

300. SKIN: Normal

301. NAILS: Normal

302. HAIR: Normal

303. EYES: Normal

304. EARS: Normal

305. NOSE: Normal

306. MOUTH: Normal

307. PHARYNX: Normal

308. LARYNX: Normal

309. TRACHEA: Normal

310. BRONCHI: Normal

311. LUNGS: Normal

312. PLEURA: Normal

313. PERICARDIUM: Normal

314. HEART: Normal

315. CORONARY ARTERIES: Normal

316. AORTA: Normal

317. PULMONARY ARTERY: Normal

318. PULMONARY VEIN: Normal

319. VESSELS: Normal

320. CAPILLARIES: Normal

321. LYMPHATIC SYSTEM: Normal

322. BLOOD: Normal

323. URINE: Normal

324. FECES: Normal

325. SWEAT: Normal

326. SALIVA: Normal

327. TEARS: Normal

328. MUCUS: Normal

329. CEREBROSPINAL FLUID: Normal

330. SPINAL FLUID: Normal

331. JOINTS: Normal

332. BONES: Normal

333. MUSCLES: Normal

334. NERVES: Normal

335. GLANDS: Normal

336. SKIN: Normal

337. NAILS: Normal

338. HAIR: Normal

339. EYES: Normal

340. EARS: Normal

341. NOSE: Normal

342. MOUTH: Normal

343. PHARYNX: Normal

344. LARYNX: Normal

345. TRACHEA: Normal

346. BRONCHI: Normal

347. LUNGS: Normal

348. PLEURA: Normal

349. PERICARDIUM: Normal

350. HEART: Normal

351. CORONARY ARTERIES: Normal

352. AORTA: Normal

353. PULMONARY ARTERY: Normal

354. PULMONARY VEIN: Normal

355. VESSELS: Normal

356. CAPILLARIES: Normal

357. LYMPHATIC SYSTEM: Normal

358. BLOOD: Normal

359. URINE: Normal

360. FECES: Normal

361. SWEAT: Normal

362. SALIVA: Normal

363. TEARS: Normal

364. MUCUS: Normal

365. CEREBROSPINAL FLUID: Normal

366. SPINAL FLUID: Normal

367. JOINTS: Normal

368. BONES: Normal

369. MUSCLES: Normal

370. NERVES: Normal

371. GLANDS: Normal

372. SKIN: Normal

373. NAILS: Normal

374. HAIR: Normal

375. EYES: Normal

376. EARS: Normal

377. NOSE: Normal

378. MOUTH: Normal

379. PHARYNX: Normal

380. LARYNX: Normal

381. TRACHEA: Normal

382. BRONCHI: Normal

383. LUNGS: Normal

384. PLEURA: Normal

385. PERICARDIUM: Normal

386. HEART: Normal

387. CORONARY ARTERIES: Normal

388. AORTA: Normal

389. PULMONARY ARTERY: Normal

390. PULMONARY VEIN: Normal

391. VESSELS: Normal

392. CAPILLARIES: Normal

393. LYMPHATIC SYSTEM: Normal

394. BLOOD: Normal

395. URINE: Normal

396. FECES: Normal

397. SWEAT: Normal

398. SALIVA: Normal

399. TEARS: Normal

400. MUCUS: Normal

401. CEREBROSPINAL FLUID: Normal

402. SPINAL FLUID: Normal

403. JOINTS: Normal

404. BONES: Normal

405. MUSCLES: Normal

406. NERVES: Normal

407. GLANDS: Normal

408. SKIN: Normal

409. NAILS: Normal

410. HAIR: Normal

411. EYES: Normal

412. EARS: Normal

413. NOSE: Normal

414. MOUTH: Normal

415. PHARYNX: Normal

416. LARYNX: Normal

417. TRACHEA: Normal

418. BRONCHI: Normal

419. LUNGS: Normal

420. PLEURA: Normal

421. PERICARDIUM: Normal

422. HEART: Normal

423. CORONARY ARTERIES: Normal

424. AORTA: Normal

425. PULMONARY ARTERY: Normal

426. PULMONARY VEIN: Normal

427. VESSELS: Normal

428. CAPILLARIES: Normal

429. LYMPHATIC SYSTEM: Normal

430. BLOOD: Normal

431. URINE: Normal

432. FECES: Normal

433. SWEAT: Normal

434. SALIVA: Normal

435. TEARS: Normal

436. MUCUS: Normal

437. CEREBROSPINAL FLUID: Normal

438. SPINAL FLUID: Normal

439. JOINTS: Normal

440. BONES: Normal

441. MUSCLES: Normal

442. NERVES: Normal

443. GLANDS: Normal

444. SKIN: Normal

445. NAILS: Normal

446. HAIR: Normal

447. EYES: Normal

448. EARS: Normal

449. NOSE: Normal

450. MOUTH: Normal

451. PHARYNX: Normal

452. LARYNX: Normal

453. TRACHEA: Normal

454. BRONCHI: Normal

455. LUNGS: Normal

456. PLEURA: Normal

457. PERICARDIUM: Normal

458. HEART: Normal

459. CORONARY ARTERIES: Normal

460. AORTA: Normal

461. PULMONARY ARTERY: Normal

462. PULMONARY VEIN: Normal

463. VESSELS: Normal

464. CAPILLARIES: Normal

465. LYMPHATIC SYSTEM: Normal

466. BLOOD: Normal

467. URINE: Normal

468. FECES: Normal

469. SWEAT: Normal

470. SALIVA: Normal

471. TEARS: Normal

472. MUCUS: Normal

473. CEREBROSPINAL FLUID: Normal

474. SPINAL FLUID: Normal

475. JOINTS: Normal

476. BONES: Normal

477. MUSCLES: Normal

478. NERVES: Normal

479. GLANDS: Normal

480. SKIN: Normal

481. NAILS: Normal

482. HAIR: Normal

483. EYES: Normal

484. EARS: Normal

485. NOSE: Normal

486. MOUTH: Normal

487. PHARYNX: Normal

488. LARYNX: Normal

489. TRACHEA: Normal

490. BRONCHI: Normal

491. LUNGS: Normal

492. PLEURA: Normal

493. PERICARDIUM: Normal

494. HEART: Normal

495. CORONARY ARTERIES: Normal

496. AORTA: Normal

497. PULMONARY ARTERY: Normal

498. PULMONARY VEIN: Normal

499. VESSELS: Normal

500. CAPILLARIES: Normal

501. LYMPHATIC SYSTEM: Normal

502. BLOOD: Normal

503. URINE: Normal

504. FECES: Normal

505. SWEAT: Normal

506. SALIVA: Normal

507. TEARS: Normal

508. MUCUS: Normal

509. CEREBROSPINAL FLUID: Normal

510. SPINAL FLUID: Normal

511. JOINTS: Normal

512. BONES: Normal

513. MUSCLES: Normal

514. NERVES: Normal

515. GLANDS: Normal

516. SKIN: Normal

517. NAILS: Normal

518. HAIR: Normal

519. EYES: Normal

520. EARS: Normal

521. NOSE: Normal

522. MOUTH: Normal

523. PHARYNX: Normal

524. LARYNX: Normal

525. TRACHEA: Normal

526. BRONCHI: Normal

527. LUNGS: Normal

528. PLEURA: Normal

529. PERICARDIUM: Normal

530. HEART: Normal

531. CORONARY ARTERIES: Normal

532. AORTA: Normal

533. PULMONARY ARTERY: Normal

534. PULMONARY VEIN: Normal

535. VESSELS: Normal

536. CAPILLARIES: Normal

537. LYMPHATIC SYSTEM: Normal

538. BLOOD: Normal

539. URINE: Normal

540. FECES: Normal

541. SWEAT: Normal

542. SALIVA: Normal

543. TEARS: Normal

544. MUCUS: Normal

545. CEREBROSPINAL FLUID: Normal

546. SPINAL FLUID: Normal

547. JOINTS: Normal

548. BONES: Normal

549. MUSCLES: Normal

550. NERVES: Normal

551. GLANDS: Normal

552. SKIN: Normal

553. NAILS: Normal

554. HAIR: Normal

555. EYES: Normal

556. EARS: Normal

557. NOSE: Normal

558. MOUTH: Normal

559. PHARYNX: Normal

560. LARYNX: Normal

561. TRACHEA: Normal

562. BRONCHI: Normal

563. LUNGS: Normal

564. PLEURA: Normal

565. PERICARDIUM: Normal

566. HEART: Normal

567. CORONARY ARTERIES: Normal

568. AORTA: Normal

569. PULMONARY ARTERY: Normal

570. PULMONARY VEIN: Normal

571. VESSELS: Normal

572. CAPILLARIES: Normal

573. LYMPHATIC SYSTEM: Normal

574. BLOOD: Normal

575. URINE: Normal

576. FECES: Normal

577. SWEAT: Normal

578. SALIVA: Normal

579. TEARS: Normal

580. MUCUS: Normal

581. CEREBROSPINAL FLUID: Normal

582. SPINAL FLUID: Normal

583. JOINTS: Normal

584. BONES: Normal

585. MUSCLES: Normal

586. NERVES: Normal

587. GLANDS: Normal

588. SKIN: Normal

589. NAILS: Normal

590. HAIR: Normal

591. EYES: Normal

592. EARS: Normal

593. NOSE: Normal

594. MOUTH: Normal

595. PHARYNX: Normal

596. LARYNX: Normal

597. TRACHEA: Normal

598. BRONCHI: Normal

599. LUNGS: Normal

600. PLEURA: Normal

601. PERICARDIUM: Normal

602. HEART: Normal

603. CORONARY ARTERIES: Normal

604. AORTA: Normal

605. PULMONARY ARTERY: Normal

606. PULMONARY VEIN: Normal

607. VESSELS: Normal

608. CAPILLARIES: Normal

609. LYMPHATIC SYSTEM: Normal

610. BLOOD: Normal

611. URINE: Normal

612. FECES: Normal

613. SWEAT: Normal

614. SALIVA: Normal

615. TEARS: Normal

616. MUCUS: Normal

617. CEREBROSPINAL FLUID: Normal

618. SPINAL FLUID: Normal

619. JOINTS: Normal

620. BONES: Normal

621. MUSCLES: Normal

622. NERVES: Normal

623. GLANDS: Normal

624. SKIN: Normal

625. NAILS: Normal

626. HAIR: Normal

627. EYES: Normal

628. EARS: Normal

629. NOSE: Normal

630. MOUTH: Normal

631. PHARYNX: Normal

632. LARYNX: Normal

633. TRACHEA: Normal

634. BRONCHI: Normal

635. LUNGS: Normal

636. PLEURA: Normal

637. PERICARDIUM: Normal

638. HEART: Normal

639. CORONARY ARTERIES: Normal

640. AORTA: Normal

641. PULMONARY ARTERY: Normal

642. PULMONARY VEIN: Normal

643. VESSELS: Normal

644. CAPILLARIES: Normal

6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05078

5033

Item 2 Film G261

CERTIFICATE OF DEATH

302

4/29/60 iwk

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 6 Weeks d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash Counth Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Downsville d. STREET ADDRESS Weburn Conv Home e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle EDWARD Last PITSNOGLE		4. DATE OF DEATH Month April Day 6 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 3 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Mason		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Pitsnogle		14. MOTHER'S MAIDEN NAME Katherine Weaver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 320-10-2010	
17. INFORMANT Mrs Gertrude Wise		Address 21 E. Baltimore St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Arteriosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Myocardial Infarction (c) Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/5/60 to 4/6/60 , that (I) (we) last saw the deceased alive on 4/6/60 , and that death occurred 4/6/60 from the causes and on the date stated above.			
22a. SIGNATURE Calvin Young		22b. DATE SIGNED 4/7/60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Williamstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/9/60	
23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland Allegany Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR APR 11 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

05018

105

STATE OF NEW YORK

105



IN SENATE
January 10, 1901
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1899
ALBANY: JAMES BRADY, PRINTER.
1901.



105

ALBANY: JAMES BRADY, PRINTER.
1901.

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5095

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

65079

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILLIAMSPORT</u>		c. LENGTH OF STAY IN 1b <u>10mo. 28 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u>		d. STREET ADDRESS <u>MAIN ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WILLIAMSPORT SANITARIUM</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD ELLSWORTH POFFENBERGER</u>				4. DATE OF DEATH Month Day Year <u>APRIL - 29 - 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT-5-1873</u>		9. AGE (In years lost birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>7 24</u>	IF UNDER 24 HRS. Hours Min. <u>7 24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM.</u>		11. BIRTHPLACE (State or foreign country) <u>NEAR KEEDYSVILLE MD U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL POFFENBERGER</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE DOUB</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>THEODORE POFFENBERGER KEEDYSVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Cardiovascular collapse</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Jm</u> DUE TO <u>arteriosclerotic heart</u> (c) <u>arteriosclerotic heart</u>						INTERVAL BETWEEN ONSET AND DEATH <u>min</u> <u>yes.</u> <u>yes.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M., from the causes and on the date stated above.							
22a. SIGNATURE <u>L. L. FUND</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>LOUIS G. GRAFT</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY-2-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 5 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15080

5039

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 1115 Virginia Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LELA Middle GRACE Last POTTS				4. DATE OF DEATH Month April Day 12 Year 1960			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1887		9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ellerton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Summers				14. MOTHER'S MAIDEN NAME Cordelia Poffenberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Miss. Margaret L. Potts Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Hypertensive Cardio-vascular Disease						INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years 11 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 9, 1960 to April 12, 1960 , that (I) (we) last saw the deceased alive on April 12, 1960 and that death occurred at 9 PM , from the causes and on the date stated above.							
22a. SIGNATURE <i>W. T. Layman, M.D.</i>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) W. T. Layman, M.D.				22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/16/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. Franklin Boyer</i> Suter - Rouzer Funeral Home				25a. REC'D BY REGISTRAR Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	
DATE Apr 18 '60							

M

081

I

O

1

pe

440X

5116

CERTIFICATE OF DEATH

Reg. Dist. No.

65081

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cascade	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cascade	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edith Middle Grace Last Pryor		4. DATE OF DEATH Month April Day 9 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1896
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Duties		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Cascade, Md.
13. FATHER'S NAME John Moser		14. MOTHER'S MAIDEN NAME Susan Nichols	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Calvin G. Pryor Sr., Cascade Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic Cardio-Vascular Disease 10 years DUE TO (c) Diabetes Mellitus 10 years		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 48 , to April 9 , 19 60 , that I last saw the deceased alive on April 9 , 19 60 , and that death occurred at 6:34 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert A. Thunfischer		ADDRESS (Street, city or town, state) Blue Ridge Summit, Pa. 10 April 60	
DATE SIGNED		DATE SIGNED	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/12/60	22c. NAME OF CEMETERY OR CREMATORY Bethel	22d. LOCATION (City, town, or county) (State) Lantz #1, Fred. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Lowe		ADDRESS Waynesboro, Pa.	
24a. REC'D BY REGISTRAR APR 12 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>1. NAME OF DECEASED _____</p>		<p>2. SEX _____</p>		<p>3. AGE _____</p>	
<p>4. DATE OF DEATH _____</p>		<p>5. TIME OF DEATH _____</p>		<p>6. PLACE OF DEATH _____</p>	
<p>7. CAUSE OF DEATH _____</p>		<p>8. MANNER OF DEATH _____</p>		<p>9. SIGNATURE OF DECEASED _____</p>	
<p>10. SIGNATURE OF WITNESS _____</p>		<p>11. SIGNATURE OF PHYSICIAN _____</p>		<p>12. SIGNATURE OF CLERK _____</p>	
<p>13. SIGNATURE OF JUDGE _____</p>		<p>14. SIGNATURE OF SHERIFF _____</p>		<p>15. SIGNATURE OF CORONER _____</p>	
<p>16. SIGNATURE OF JURY _____</p>		<p>17. SIGNATURE OF DISTRICT ATTORNEY _____</p>		<p>18. SIGNATURE OF COUNTY CLERK _____</p>	
<p>19. SIGNATURE OF STATE CLERK _____</p>		<p>20. SIGNATURE OF SECRETARY OF HEALTH _____</p>		<p>21. SIGNATURE OF COMMISSIONER OF HEALTH _____</p>	
<p>22. SIGNATURE OF GOVERNOR _____</p>		<p>23. SIGNATURE OF PRESIDENT _____</p>		<p>24. SIGNATURE OF VICE PRESIDENT _____</p>	

1
M
081
I
D
1
VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

65082

5040

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASH MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wash	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JENNIE Middle W. Last PRYOR		4. DATE OF DEATH Month April Day 13 Year 19 60	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887 1867 Feb. 8
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY nothing	
11. BIRTHPLACE (State or foreign country) Frederick County Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joel Willard		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Howard Schilling, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause last. (b) Arteriosclerosis Generalized DUE TO (c) Cerebral Vascular hemorrhage		INTERVAL BETWEEN ONSET AND DEATH minutes yrs. 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psoriasis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 53 to April 13 19 60 , that I last saw the deceased alive on April 13, 1960 , and that death occurred at 6: 45 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 4-13-60	
ACTUAL SIGNATURE Louis G. Graff M.D.			
PHYSICIAN'S NAME (Type) Louis G. Graff, M.D.		119 E. Antietam St. Hagerstown	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/16/60	22c. NAME OF CEMETERY OR CREMATORY Bethel	22d. LOCATION (City, town, or county) (State) Lantz Md. R.D.1
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Shaw		24a. REC'D BY REGISTRAR DATE APR 18 '60	
ADDRESS Waynesboro, Pa.		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5041

CERTIFICATE OF DEATH

Reg. Dist. No.

65083

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARTIN MANOR REST HOME 1222 Virginia Ave.,		d. STREET ADDRESS Saint Paul's	
3. NAME OF DECEASED (Type or print) First Middle Last LUELLA WHITE PRYOR		4. DATE OF DEATH Month Day Year APRIL 15 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 7 1884
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	
11. BIRTHPLACE (State or foreign country) EMMITSBURG, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WALTER W. WHITE		14. MOTHER'S MAIDEN NAME FANNIE ROWE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Earl Knepper, Clear Spring, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC NEPHRITIS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 26, 1960, to April 15, 1960, that I last saw the deceased alive on April 14, 1960, 12, and that death occurred at 5:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Archie Robert Cohen, M.D.		Clear Spring, Maryland April 15, 1960	
PHYSICIAN'S NAME (Type)		Clear Spring, Maryland April 15, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/60	
22c. NAME OF CEMETERY OR CREMATORY Mt. View		22d. LOCATION (City, town, or county) (State) Emmitsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson		ADDRESS Emmitsburg, Md.	
24a. REC'D BY REGISTRAR DATE APR 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

420.0

PLACE OF BIRTH		MARRIAGE		EDUCATION	
BALTIMORE		MARRIED		HIGH SCHOOL	
DATE OF BIRTH		DATE OF MARRIAGE		DATE OF DEATH	
JAN 1 1880		JAN 1 1900		JAN 1 1903	
AGE		SEX		RACE	
23 YEARS		MALE		WHITE	
OCCUPATION		RELIGION		CAUSE OF DEATH	
LABORER		METHODIST		HEART DISEASE	
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
BALTIMORE		JAN 1 1903		10:00 AM	
MANNER OF DEATH		CERTIFICATE NO.		SIGNATURE	
NATURAL		1000		J. H. [Signature]	
LOCALITY		COUNTY		STATE	
BALTIMORE		BALTIMORE		MARYLAND	
DATE OF REPORT		REPORTED BY		SIGNATURE	
JAN 1 1903		J. H. [Signature]		J. H. [Signature]	

RECEIVED
 JAN 1 1903
 BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5117 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65084

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Hook		c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Hook			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Residence				d. STREET ADDRESS Old U.S. 340		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GRACE Middle PEARL Last RAY				4. DATE OF DEATH Month April Day 6 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 30, 1881		9. AGE (in years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Tom's Brook, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James William Ray				14. MOTHER'S MAIDEN NAME Marian Dawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Mrs. Melvin O. Hoar 712 B. St., Brunswick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio Vascular Disease DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 5 hrs? 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE [Signature]		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. D. T. O. 2		DATE SIGNED 4/6/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/8/60	22c. NAME OF CEMETERY OR CREMATORY Virts Cemetery		22d. LOCATION (City, town, or county) (State) Sandy Hook, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Harpers Ferry, W.V.		24a. REC'D BY REGISTRAR DATE APR 11 '60		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF EXAMINER		11. SIGNATURE OF WITNESS		12. SIGNATURE OF CORONER		13. SIGNATURE OF JURY		14. SIGNATURE OF JUDGE		15. SIGNATURE OF CLERK		16. SIGNATURE OF SHERIFF		17. SIGNATURE OF DEPUTY SHERIFF		18. SIGNATURE OF CONSTABLE		19. SIGNATURE OF JAILER		20. SIGNATURE OF WATCHMAN		21. SIGNATURE OF DOORKEEPER		22. SIGNATURE OF CHIEF OF POLICE		23. SIGNATURE OF DEPUTY CHIEF OF POLICE		24. SIGNATURE OF SQUAD LEADER		25. SIGNATURE OF OFFICER		26. SIGNATURE OF DETECTIVE		27. SIGNATURE OF PATROLMAN		28. SIGNATURE OF TRAFFIC OFFICER		29. SIGNATURE OF INVESTIGATOR		30. SIGNATURE OF RECORDS CLERK		31. SIGNATURE OF CHIEF OF BUREAU		32. SIGNATURE OF DEPUTY CHIEF OF BUREAU		33. SIGNATURE OF ASST. CHIEF OF BUREAU		34. SIGNATURE OF CHIEF OF DIVISION		35. SIGNATURE OF DEPUTY CHIEF OF DIVISION		36. SIGNATURE OF ASST. CHIEF OF DIVISION		37. SIGNATURE OF CHIEF OF SECTION		38. SIGNATURE OF DEPUTY CHIEF OF SECTION		39. SIGNATURE OF ASST. CHIEF OF SECTION		40. SIGNATURE OF CHIEF OF UNIT		41. SIGNATURE OF DEPUTY CHIEF OF UNIT		42. SIGNATURE OF ASST. CHIEF OF UNIT		43. SIGNATURE OF CHIEF OF SQUAD		44. SIGNATURE OF DEPUTY CHIEF OF SQUAD		45. SIGNATURE OF ASST. CHIEF OF SQUAD		46. SIGNATURE OF CHIEF OF TEAM		47. SIGNATURE OF DEPUTY CHIEF OF TEAM		48. SIGNATURE OF ASST. CHIEF OF TEAM		49. SIGNATURE OF CHIEF OF POST		50. SIGNATURE OF DEPUTY CHIEF OF POST		51. SIGNATURE OF ASST. CHIEF OF POST		52. SIGNATURE OF CHIEF OF PLATOON		53. SIGNATURE OF DEPUTY CHIEF OF PLATOON		54. SIGNATURE OF ASST. CHIEF OF PLATOON		55. SIGNATURE OF CHIEF OF COMPANY		56. SIGNATURE OF DEPUTY CHIEF OF COMPANY		57. SIGNATURE OF ASST. CHIEF OF COMPANY		58. SIGNATURE OF CHIEF OF BATTALION		59. SIGNATURE OF DEPUTY CHIEF OF BATTALION		60. SIGNATURE OF ASST. CHIEF OF BATTALION		61. SIGNATURE OF CHIEF OF REGIMENT		62. SIGNATURE OF DEPUTY CHIEF OF REGIMENT		63. SIGNATURE OF ASST. CHIEF OF REGIMENT		64. SIGNATURE OF CHIEF OF BRIGADE		65. SIGNATURE OF DEPUTY CHIEF OF BRIGADE		66. SIGNATURE OF ASST. CHIEF OF BRIGADE		67. SIGNATURE OF CHIEF OF DIVISION		68. SIGNATURE OF DEPUTY CHIEF OF DIVISION		69. SIGNATURE OF ASST. CHIEF OF DIVISION		70. SIGNATURE OF CHIEF OF DEPARTMENT		71. SIGNATURE OF DEPUTY CHIEF OF DEPARTMENT		72. SIGNATURE OF ASST. CHIEF OF DEPARTMENT		73. SIGNATURE OF CHIEF OF STATE		74. SIGNATURE OF DEPUTY CHIEF OF STATE		75. SIGNATURE OF ASST. CHIEF OF STATE		76. SIGNATURE OF CHIEF OF NATION		77. SIGNATURE OF DEPUTY CHIEF OF NATION		78. SIGNATURE OF ASST. CHIEF OF NATION		79. SIGNATURE OF CHIEF OF WORLD		80. SIGNATURE OF DEPUTY CHIEF OF WORLD		81. SIGNATURE OF ASST. CHIEF OF WORLD		82. SIGNATURE OF CHIEF OF UNIVERSE		83. SIGNATURE OF DEPUTY CHIEF OF UNIVERSE		84. SIGNATURE OF ASST. CHIEF OF UNIVERSE		85. SIGNATURE OF CHIEF OF GOD		86. SIGNATURE OF DEPUTY CHIEF OF GOD		87. SIGNATURE OF ASST. CHIEF OF GOD		88. SIGNATURE OF CHIEF OF HEAVEN		89. SIGNATURE OF DEPUTY CHIEF OF HEAVEN		90. SIGNATURE OF ASST. CHIEF OF HEAVEN		91. SIGNATURE OF CHIEF OF EARTH		92. SIGNATURE OF DEPUTY CHIEF OF EARTH		93. SIGNATURE OF ASST. CHIEF OF EARTH		94. SIGNATURE OF CHIEF OF WATER		95. SIGNATURE OF DEPUTY CHIEF OF WATER		96. SIGNATURE OF ASST. CHIEF OF WATER		97. SIGNATURE OF CHIEF OF FIRE		98. SIGNATURE OF DEPUTY CHIEF OF FIRE		99. SIGNATURE OF ASST. CHIEF OF FIRE		100. SIGNATURE OF CHIEF OF AIR		101. SIGNATURE OF DEPUTY CHIEF OF AIR		102. SIGNATURE OF ASST. CHIEF OF AIR		103. SIGNATURE OF CHIEF OF SPACE		104. SIGNATURE OF DEPUTY CHIEF OF SPACE		105. SIGNATURE OF ASST. CHIEF OF SPACE		106. SIGNATURE OF CHIEF OF TIME		107. SIGNATURE OF DEPUTY CHIEF OF TIME		108. SIGNATURE OF ASST. CHIEF OF TIME		109. SIGNATURE OF CHIEF OF MATTER		110. SIGNATURE OF DEPUTY CHIEF OF MATTER		111. SIGNATURE OF ASST. CHIEF OF MATTER		112. SIGNATURE OF CHIEF OF ENERGY		113. SIGNATURE OF DEPUTY CHIEF OF ENERGY		114. SIGNATURE OF ASST. CHIEF OF ENERGY		115. SIGNATURE OF CHIEF OF LIFE		116. SIGNATURE OF DEPUTY CHIEF OF LIFE		117. SIGNATURE OF ASST. CHIEF OF LIFE		118. SIGNATURE OF CHIEF OF DEATH		119. SIGNATURE OF DEPUTY CHIEF OF DEATH		120. SIGNATURE OF ASST. CHIEF OF DEATH		121. SIGNATURE OF CHIEF OF SLEEP		122. SIGNATURE OF DEPUTY CHIEF OF SLEEP		123. SIGNATURE OF ASST. CHIEF OF SLEEP		124. SIGNATURE OF CHIEF OF WAKE		125. SIGNATURE OF DEPUTY CHIEF OF WAKE		126. SIGNATURE OF ASST. CHIEF OF WAKE		127. SIGNATURE OF CHIEF OF HAPPINESS		128. SIGNATURE OF DEPUTY CHIEF OF HAPPINESS		129. SIGNATURE OF ASST. CHIEF OF HAPPINESS		130. SIGNATURE OF CHIEF OF SADNESS		131. SIGNATURE OF DEPUTY CHIEF OF SADNESS		132. SIGNATURE OF ASST. CHIEF OF SADNESS		133. SIGNATURE OF CHIEF OF LOVE		134. SIGNATURE OF DEPUTY CHIEF OF LOVE		135. SIGNATURE OF ASST. CHIEF OF LOVE		136. SIGNATURE OF CHIEF OF HATE		137. SIGNATURE OF DEPUTY CHIEF OF HATE		138. SIGNATURE OF ASST. CHIEF OF HATE		139. SIGNATURE OF CHIEF OF GOOD		140. SIGNATURE OF DEPUTY CHIEF OF GOOD		141. SIGNATURE OF ASST. CHIEF OF GOOD		142. SIGNATURE OF CHIEF OF EVIL		143. SIGNATURE OF DEPUTY CHIEF OF EVIL		144. SIGNATURE OF ASST. CHIEF OF EVIL		145. SIGNATURE OF CHIEF OF LIGHT		146. SIGNATURE OF DEPUTY CHIEF OF LIGHT		147. SIGNATURE OF ASST. CHIEF OF LIGHT		148. SIGNATURE OF CHIEF OF DARKNESS		149. SIGNATURE OF DEPUTY CHIEF OF DARKNESS		150. SIGNATURE OF ASST. CHIEF OF DARKNESS		151. SIGNATURE OF CHIEF OF HEAT		152. SIGNATURE OF DEPUTY CHIEF OF HEAT		153. SIGNATURE OF ASST. CHIEF OF HEAT		154. SIGNATURE OF CHIEF OF COLD		155. SIGNATURE OF DEPUTY CHIEF OF COLD		156. SIGNATURE OF ASST. CHIEF OF COLD		157. SIGNATURE OF CHIEF OF DRY		158. SIGNATURE OF DEPUTY CHIEF OF DRY		159. SIGNATURE OF ASST. CHIEF OF DRY		160. SIGNATURE OF CHIEF OF WET		161. SIGNATURE OF DEPUTY CHIEF OF WET		162. SIGNATURE OF ASST. CHIEF OF WET		163. SIGNATURE OF CHIEF OF HOT		164. SIGNATURE OF DEPUTY CHIEF OF HOT		165. SIGNATURE OF ASST. CHIEF OF HOT		166. SIGNATURE OF CHIEF OF COOL		167. SIGNATURE OF DEPUTY CHIEF OF COOL		168. SIGNATURE OF ASST. CHIEF OF COOL		169. SIGNATURE OF CHIEF OF FAST		170. SIGNATURE OF DEPUTY CHIEF OF FAST		171. SIGNATURE OF ASST. CHIEF OF FAST		172. SIGNATURE OF CHIEF OF SLOW		173. SIGNATURE OF DEPUTY CHIEF OF SLOW		174. SIGNATURE OF ASST. CHIEF OF SLOW		175. SIGNATURE OF CHIEF OF QUICK		176. SIGNATURE OF DEPUTY CHIEF OF QUICK		177. SIGNATURE OF ASST. CHIEF OF QUICK		178. SIGNATURE OF CHIEF OF STUPID		179. SIGNATURE OF DEPUTY CHIEF OF STUPID		180. SIGNATURE OF ASST. CHIEF OF STUPID		181. SIGNATURE OF CHIEF OF SMART		182. SIGNATURE OF DEPUTY CHIEF OF SMART		183. SIGNATURE OF ASST. CHIEF OF SMART		184. SIGNATURE OF CHIEF OF DUMB		185. SIGNATURE OF DEPUTY CHIEF OF DUMB		186. SIGNATURE OF ASST. CHIEF OF DUMB		187. SIGNATURE OF CHIEF OF BRAVE		188. SIGNATURE OF DEPUTY CHIEF OF BRAVE		189. SIGNATURE OF ASST. CHIEF OF BRAVE		190. SIGNATURE OF CHIEF OF COWARDLY		191. SIGNATURE OF DEPUTY CHIEF OF COWARDLY		192. SIGNATURE OF ASST. CHIEF OF COWARDLY		193. SIGNATURE OF CHIEF OF COURAGEOUS		194. SIGNATURE OF DEPUTY CHIEF OF COURAGEOUS		195. SIGNATURE OF ASST. CHIEF OF COURAGEOUS		196. SIGNATURE OF CHIEF OF SCARED		197. SIGNATURE OF DEPUTY CHIEF OF SCARED		198. SIGNATURE OF ASST. CHIEF OF SCARED		199. SIGNATURE OF CHIEF OF CONFIDENT		200. SIGNATURE OF DEPUTY CHIEF OF CONFIDENT		201. SIGNATURE OF ASST. CHIEF OF CONFIDENT		202. SIGNATURE OF CHIEF OF SHY		203. SIGNATURE OF DEPUTY CHIEF OF SHY		204. SIGNATURE OF ASST. CHIEF OF SHY		205. SIGNATURE OF CHIEF OF BOLD		206. SIGNATURE OF DEPUTY CHIEF OF BOLD		207. SIGNATURE OF ASST. CHIEF OF BOLD		208. SIGNATURE OF CHIEF OF MEAN		209. SIGNATURE OF DEPUTY CHIEF OF MEAN		210. SIGNATURE OF ASST. CHIEF OF MEAN		211. SIGNATURE OF CHIEF OF NICE		212. SIGNATURE OF DEPUTY CHIEF OF NICE		213. SIGNATURE OF ASST. CHIEF OF NICE		214. SIGNATURE OF CHIEF OF CRUEL		215. SIGNATURE OF DEPUTY CHIEF OF CRUEL		216. SIGNATURE OF ASST. CHIEF OF CRUEL		217. SIGNATURE OF CHIEF OF KIND		218. SIGNATURE OF DEPUTY CHIEF OF KIND		219. SIGNATURE OF ASST. CHIEF OF KIND		220. SIGNATURE OF CHIEF OF UNKIND		221. SIGNATURE OF DEPUTY CHIEF OF UNKIND		222. SIGNATURE OF ASST. CHIEF OF UNKIND		223. SIGNATURE OF CHIEF OF GENTLE		224. SIGNATURE OF DEPUTY CHIEF OF GENTLE		225. SIGNATURE OF ASST. CHIEF OF GENTLE		226. SIGNATURE OF CHIEF OF RAGGED		227. SIGNATURE OF DEPUTY CHIEF OF RAGGED		228. SIGNATURE OF ASST. CHIEF OF RAGGED		229. SIGNATURE OF CHIEF OF SMOOTH		230. SIGNATURE OF DEPUTY CHIEF OF SMOOTH		231. SIGNATURE OF ASST. CHIEF OF SMOOTH		232. SIGNATURE OF CHIEF OF HARD		233. SIGNATURE OF DEPUTY CHIEF OF HARD		234. SIGNATURE OF ASST. CHIEF OF HARD		235. SIGNATURE OF CHIEF OF SOFT		236. SIGNATURE OF DEPUTY CHIEF OF SOFT		237. SIGNATURE OF ASST. CHIEF OF SOFT		238. SIGNATURE OF CHIEF OF TIGHT		239. SIGNATURE OF DEPUTY CHIEF OF TIGHT		240. SIGNATURE OF ASST. CHIEF OF TIGHT		241. SIGNATURE OF CHIEF OF LOOSE		242. SIGNATURE OF DEPUTY CHIEF OF LOOSE		243. SIGNATURE OF ASST. CHIEF OF LOOSE		244. SIGNATURE OF CHIEF OF CLEAN		245. SIGNATURE OF DEPUTY CHIEF OF CLEAN		246. SIGNATURE OF ASST. CHIEF OF CLEAN		247. SIGNATURE OF CHIEF OF DIRTY		248. SIGNATURE OF DEPUTY CHIEF OF DIRTY		249. SIGNATURE OF ASST. CHIEF OF DIRTY		250. SIGNATURE OF CHIEF OF FRESH		251. SIGNATURE OF DEPUTY CHIEF OF FRESH		252. SIGNATURE OF ASST. CHIEF OF FRESH		253. SIGNATURE OF CHIEF OF STALE		254. SIGNATURE OF DEPUTY CHIEF OF STALE		255. SIGNATURE OF ASST. CHIEF OF STALE		256. SIGNATURE OF CHIEF OF NEW		257. SIGNATURE OF DEPUTY CHIEF OF NEW		258. SIGNATURE OF ASST. CHIEF OF NEW		259. SIGNATURE OF CHIEF OF OLD		260. SIGNATURE OF DEPUTY CHIEF OF OLD		261. SIGNATURE OF ASST. CHIEF OF OLD		262. SIGNATURE OF CHIEF OF YOUNG		263. SIGNATURE OF DEPUTY CHIEF OF YOUNG		264. SIGNATURE OF ASST. CHIEF OF YOUNG		265. SIGNATURE OF CHIEF OF OLD		266. SIGNATURE OF DEPUTY CHIEF OF OLD		267. SIGNATURE OF ASST. CHIEF OF OLD		268. SIGNATURE OF CHIEF OF INFANT		269. SIGNATURE OF DEPUTY CHIEF OF INFANT		270. SIGNATURE OF ASST. CHIEF OF INFANT		271. SIGNATURE OF CHIEF OF ADULT		272. SIGNATURE OF DEPUTY CHIEF OF ADULT		273. SIGNATURE OF ASST. CHIEF OF ADULT		274. SIGNATURE OF CHIEF OF CHILD		275. SIGNATURE OF DEPUTY CHIEF OF CHILD		276. SIGNATURE OF ASST. CHIEF OF CHILD		277. SIGNATURE OF CHIEF OF YOUTH		278. SIGNATURE OF DEPUTY CHIEF OF YOUTH		279. SIGNATURE OF ASST. CHIEF OF YOUTH		280. SIGNATURE OF CHIEF OF ELDERLY		281. SIGNATURE OF DEPUTY CHIEF OF ELDERLY		282. SIGNATURE OF ASST. CHIEF OF ELDERLY		283. SIGNATURE OF CHIEF OF YOUNG		284. SIGNATURE OF DEPUTY CHIEF OF YOUNG		285. SIGNATURE OF ASST. CHIEF OF YOUNG		286. SIGNATURE OF CHIEF OF OLD		287. SIGNATURE OF DEPUTY CHIEF OF OLD		288. SIGNATURE OF ASST. CHIEF OF OLD		289. SIGNATURE OF CHIEF OF INFANT		290. SIGNATURE OF DEPUTY CHIEF OF INFANT		291. SIGNATURE OF ASST. CHIEF OF INFANT		292. SIGNATURE OF CHIEF OF ADULT		293. SIGNATURE OF DEPUTY CHIEF OF ADULT		294. SIGNATURE OF ASST. CHIEF OF ADULT		295. SIGNATURE OF CHIEF OF CHILD		296. SIGNATURE OF DEPUTY CHIEF OF CHILD		297. SIGNATURE OF ASST. CHIEF OF CHILD		298. SIGNATURE OF CHIEF OF YOUTH		299. SIGNATURE OF DEPUTY CHIEF OF YOUTH		300. SIGNATURE OF ASST. CHIEF OF YOUTH		301. SIGNATURE OF CHIEF OF ELDERLY		302. SIGNATURE OF DEPUTY CHIEF OF ELDERLY		303. SIGNATURE OF ASST. CHIEF OF ELDERLY		304. SIGNATURE OF CHIEF OF YOUNG		305. SIGNATURE OF DEPUTY CHIEF OF YOUNG		306. SIGNATURE OF ASST. CHIEF OF YOUNG		307. SIGNATURE OF CHIEF OF OLD		308. SIGNATURE OF DEPUTY CHIEF OF OLD		309. SIGNATURE OF ASST. CHIEF OF OLD		310. SIGNATURE OF CHIEF OF INFANT		311. SIGNATURE OF DEPUTY CHIEF OF INFANT		312. SIGNATURE OF ASST. CHIEF OF INFANT		313. SIGNATURE OF CHIEF OF ADULT		314. SIGNATURE OF DEPUTY CHIEF OF ADULT		315. SIGNATURE OF ASST. CHIEF OF ADULT		316. SIGNATURE OF CHIEF OF CHILD		317. SIGNATURE OF DEPUTY CHIEF OF CHILD		318. SIGNATURE OF ASST. CHIEF OF CHILD		319. SIGNATURE OF CHIEF OF YOUTH		320. SIGNATURE OF DEPUTY CHIEF OF YOUTH		321. SIGNATURE OF ASST. CHIEF OF YOUTH		322. SIGNATURE OF CHIEF OF ELDERLY		323. SIGNATURE OF DEPUTY CHIEF OF ELDERLY		324. SIGNATURE OF ASST. CHIEF OF ELDERLY		325. SIGNATURE OF CHIEF OF YOUNG		326. SIGNATURE OF DEPUTY CHIEF OF YOUNG		327. SIGNATURE OF ASST. CHIEF OF YOUNG		328. SIGNATURE OF CHIEF OF OLD		329. SIGNATURE OF DEPUTY CHIEF OF OLD		330. SIGNATURE OF ASST. CHIEF OF OLD		331. SIGNATURE OF CHIEF OF INFANT		332. SIGNATURE OF DEPUTY CHIEF OF INFANT		333. SIGNATURE OF ASST. CHIEF OF INFANT		334. SIGNATURE OF CHIEF OF ADULT		335. SIGNATURE OF DEPUTY CHIEF OF ADULT		336. SIGNATURE OF ASST. CHIEF OF ADULT		337. SIGNATURE OF CHIEF OF CHILD		338. SIGNATURE OF DEPUTY CHIEF OF CHILD		339. SIGNATURE OF ASST. CHIEF OF CHILD		340. SIGNATURE OF CHIEF OF YOUTH		341. SIGNATURE OF DEPUTY CHIEF OF YOUTH		342. SIGNATURE OF ASST. CHIEF OF YOUTH		343. SIGNATURE OF CHIEF OF ELDERLY		344. SIGNATURE OF DEPUTY CHIEF OF ELDERLY		345. SIGNATURE OF ASST. CHIEF OF ELDERLY		346. SIGNATURE OF CHIEF OF YOUNG		347. SIGNATURE OF DEPUTY CHIEF OF YOUNG		348. SIGNATURE OF ASST. CHIEF OF YOUNG		349. SIGNATURE OF CHIEF OF OLD		350. SIGNATURE OF DEPUTY CHIEF OF OLD		351. SIGNATURE OF ASST. CHIEF OF OLD		352. SIGNATURE OF CHIEF OF INFANT		353. SIGNATURE OF DEPUTY CHIEF OF INFANT		354. SIGNATURE OF ASST. CHIEF OF INFANT		355. SIGNATURE OF CHIEF OF ADULT		356. SIGNATURE OF DEPUTY CHIEF OF ADULT		357. SIGNATURE OF ASST. CHIEF OF ADULT		358. SIGNATURE OF CHIEF OF CHILD		359. SIGNATURE OF DEPUTY CHIEF OF CHILD		360. SIGNATURE OF ASST. CHIEF OF CHILD		361. SIGNATURE OF CHIEF OF YOUTH		362. SIGNATURE OF DEPUTY CHIEF OF YOUTH		363. SIGNATURE OF ASST. CHIEF OF YOUTH		364. SIGNATURE OF CHIEF OF ELDERLY		365. SIGNATURE OF DEPUTY CHIEF OF ELDERLY		366. SIGNATURE OF ASST. CHIEF OF ELDERLY		367. SIGNATURE OF CHIEF OF YOUNG		368. SIGNATURE OF DEPUTY CHIEF OF YOUNG		369. SIGNATURE OF ASST. CHIEF OF YOUNG		370. SIGNATURE OF CHIEF OF OLD		371. SIGNATURE OF DEPUTY CHIEF OF OLD		372. SIGNATURE OF ASST. CHIEF OF OLD		373. SIGNATURE OF CHIEF OF INFANT		374. SIGNATURE OF DEPUTY CHIEF OF INFANT		375. SIGNATURE OF ASST. CHIEF OF INFANT		376. SIGNATURE OF CHIEF OF ADULT		377. SIGNATURE OF DEPUTY CHIEF OF ADULT		378. SIGNATURE OF ASST. CHIEF OF ADULT		379. SIGNATURE OF CHIEF OF CHILD		380. SIGNATURE OF DEPUTY CHIEF OF CHILD		381. SIGNATURE OF ASST. CHIEF OF CHILD		382. SIGNATURE OF CHIEF OF YOUTH		383. SIGNATURE OF DEPUTY CHIEF OF YOUTH		384. SIGNATURE OF ASST. CHIEF OF YOUTH		385. SIGNATURE OF CHIEF OF ELDERLY		386. SIGNATURE OF DEPUTY CHIEF OF ELDERLY		387. SIGNATURE OF ASST. CHIEF OF ELDERLY		388. SIGNATURE OF CHIEF OF YOUNG		389. SIGNATURE OF DEPUTY CHIEF OF YOUNG		390. SIGNATURE OF ASST. CHIEF OF YOUNG		391. SIGNATURE OF CHIEF OF OLD		392. SIGNATURE OF DEPUTY CHIEF OF OLD		393. SIGNATURE OF ASST. CHIEF OF OLD		394. SIGNATURE OF CHIEF OF INFANT		395. SIGNATURE OF DEPUTY CHIEF OF INFANT		396. SIGNATURE OF ASST. CHIEF OF INFANT		397. SIGNATURE OF CHIEF OF ADULT		398. SIGNATURE OF DEPUTY CHIEF OF ADULT		399. SIGNATURE OF ASST. CHIEF OF ADULT		400. SIGNATURE OF CHIEF OF CHILD		401. SIGNATURE OF DEPUTY CHIEF OF CHILD		402. SIGNATURE OF ASST. CHIEF OF CHILD		403. SIGNATURE OF CHIEF OF YOUTH		404. SIGNATURE OF DEPUTY CHIEF OF YOUTH		405. SIGNATURE OF ASST. CHIEF OF YOUTH		406. SIGNATURE OF CHIEF OF ELDERLY		407. SIGNATURE OF DEPUTY CHIEF OF ELDERLY		408. SIGNATURE OF ASST. CHIEF OF ELDERLY		409. SIGNATURE OF CHIEF OF YOUNG		410. SIGNATURE OF DEPUTY CHIEF OF YOUNG		411. SIGNATURE OF ASST. CHIEF OF YOUNG		412. SIGNATURE OF CHIEF OF OLD		413. SIGNATURE OF DEPUTY CHIEF OF OLD		414. SIGNATURE OF ASST. CHIEF OF OLD		415. SIGNATURE OF CHIEF OF INFANT		416. SIGNATURE OF DEPUTY CHIEF OF INFANT		417. SIGNATURE OF ASST. CHIEF OF INFANT		418. SIGNATURE OF CHIEF OF ADULT		419. SIGNATURE OF DEPUTY CHIEF OF ADULT		420. SIGNATURE OF ASST. CHIEF OF ADULT		421. SIGNATURE OF CHIEF OF CHILD		422. SIGNATURE OF DEPUTY CHIEF OF CHILD		423. SIGNATURE OF ASST. CHIEF OF CHILD		424. SIGNATURE OF CHIEF OF YOUTH		425. SIGNATURE OF DEPUTY CHIEF OF YOUTH		426. SIGNATURE OF ASST. CHIEF OF YOUTH		427. SIGNATURE OF CHIEF OF ELDERLY		428. SIGNATURE OF DEPUTY CHIEF OF ELDERLY		429. SIGNATURE OF ASST. CHIEF OF ELDERLY		430. SIGNATURE OF CHIEF OF YOUNG		431. SIGNATURE OF DEPUTY CHIEF OF YOUNG		432. SIGNATURE OF ASST. CHIEF OF YOUNG		433. SIGNATURE OF CHIEF OF OLD		434. SIGNATURE OF DEPUTY CHIEF OF OLD		435. SIGNATURE OF ASST. CHIEF OF OLD		436. SIGNATURE OF CHIEF OF INFANT		437. SIGNATURE OF DEPUTY CHIEF OF INFANT		438. SIGNATURE OF ASST. CHIEF OF INFANT		439. SIGNATURE OF CHIEF OF ADULT		440. SIGNATURE OF DEPUTY CHIEF OF ADULT		441. SIGNATURE OF ASST. CHIEF OF ADULT		442. SIGNATURE OF CHIEF OF CHILD		443. SIGNATURE OF DEPUTY CHIEF OF CHILD		444. SIGNATURE OF ASST. CHIEF OF CHILD		445. SIGNATURE OF CHIEF OF YOUTH		446. SIGNATURE OF DEPUTY CHIEF OF YOUTH		447. SIGNATURE OF ASST. CHIEF OF YOUTH		448. SIGNATURE OF CHIEF OF ELDERLY		449. SIGNATURE OF DEPUTY CHIEF OF ELDERLY		450. SIGNATURE OF ASST. CHIEF OF ELDERLY		451. SIGNATURE OF CHIEF OF YOUNG		452. SIGNATURE OF DEPUTY CHIEF OF YOUNG		453. SIGNATURE OF ASST. CHIEF OF YOUNG		454. SIGNATURE OF CHIEF OF OLD		455. SIGNATURE OF DEPUTY CHIEF OF OLD		456. SIGNATURE OF ASST. CHIEF OF OLD		457. SIGNATURE OF CHIEF OF INFANT		458. SIGNATURE OF DEPUTY CHIEF OF INFANT		459. SIGNATURE OF ASST. CHIEF OF INFANT		460. SIGNATURE OF CHIEF OF ADULT		461. SIGNATURE OF DEPUTY CHIEF OF ADULT		462. SIGNATURE OF ASST. CHIEF OF ADULT		463. SIGNATURE OF CHIEF OF CHILD		464. SIGNATURE OF DEPUTY CHIEF OF CHILD		465. SIGNATURE OF ASST. CHIEF OF CHILD		466. SIGNATURE OF CHIEF OF YOUTH		467. SIGNATURE OF DEPUTY CHIEF OF YOUTH		468. SIGNATURE OF ASST. CHIEF OF YOUTH		469. SIGNATURE OF CHIEF OF ELDERLY		470. SIGNATURE OF DEPUTY CHIEF OF ELDERLY		471. SIGNATURE OF ASST. CHIEF OF ELDERLY		472. SIGNATURE OF CHIEF OF YOUNG		473. SIGNATURE OF DEPUTY CHIEF OF YOUNG		474. SIGNATURE OF ASST. CHIEF OF YOUNG		475. SIGNATURE OF CHIEF OF OLD		476. SIGNATURE OF DEPUTY CHIEF OF OLD		477. SIGNATURE OF ASST. CHIEF OF OLD		478. SIGNATURE OF CHIEF OF INFANT		479. SIGNATURE OF DEPUTY CHIEF OF INFANT		480. SIGNATURE OF ASST. CHIEF OF INFANT		481. SIGNATURE OF CHIEF OF ADULT		482. SIGNATURE OF DEPUTY CHIEF OF ADULT		483. SIGNATURE OF ASST. CHIEF OF ADULT		484. SIGNATURE OF CHIEF OF CHILD		485. SIGNATURE OF DEPUTY CHIEF OF CHILD		486. SIGNATURE OF ASST. CHIEF OF CHILD		487. SIGNATURE OF CHIEF OF YOUTH		488. SIGNATURE OF DEPUTY CHIEF OF YOUTH		489. SIGNATURE OF ASST. CHIEF OF YOUTH		490. SIGNATURE OF CHIEF OF ELDERLY		491. SIGNATURE OF DEPUTY CHIEF OF ELDERLY		492. SIGNATURE OF ASST. CHIEF OF ELDERLY		493. SIGNATURE OF CHIEF OF YOUNG		494. SIGNATURE OF DEPUTY CHIEF OF YOUNG		495. SIGNATURE OF ASST. CHIEF OF YOUNG		496. SIGNATURE OF CHIEF OF OLD		497. SIGNATURE OF DEPUTY CHIEF OF OLD		498. SIGNATURE OF ASST. CHIEF OF OLD		499. SIGNATURE OF CHIEF OF INFANT		500. SIGNATURE OF DEPUTY CHIEF OF INFANT		501. SIGNATURE OF ASST. CHIEF OF INFANT		502. SIGNATURE OF CHIEF OF ADULT		503. SIGNATURE OF DEPUTY CHIEF OF ADULT		504. SIGNATURE OF ASST. CHIEF OF ADULT		505. SIGNATURE OF CHIEF OF CHILD		506. SIGNATURE OF DEPUTY CHIEF OF CHILD		507. SIGNATURE OF ASST. CHIEF OF CHILD		508. SIGNATURE OF CHIEF OF YOUTH		509. SIGNATURE OF DEPUTY CHIEF OF YOUTH		510. SIGNATURE OF ASST. CHIEF OF YOUTH		511. SIGNATURE OF CHIEF OF ELDERLY		512. SIGNATURE OF DEPUTY CHIEF OF ELDERLY		513. SIGNATURE OF ASST. CHIEF OF ELDERLY		514. SIGNATURE OF CHIEF OF YOUNG		515. SIGNATURE OF DEPUTY CHIEF OF YOUNG		516. SIGNATURE OF ASST. CHIEF OF YOUNG		517. SIGNATURE OF CHIEF OF OLD		518. SIGNATURE OF DEPUTY CHIEF OF OLD		519. SIGNATURE OF ASST. CHIEF OF OLD		520. SIGNATURE OF CHIEF OF INFANT		521. SIGNATURE OF DEPUTY CHIEF OF INFANT		522. SIGNATURE OF ASST. CHIEF OF INFANT		523. SIGNATURE OF CHIEF OF ADULT		524. SIGNATURE OF DEPUTY CHIEF OF ADULT		525. SIGNATURE OF ASST. CHIEF OF ADULT		526. SIGNATURE OF CHIEF OF CHILD		527. SIGNATURE OF DEPUTY CHIEF OF CHILD		528. SIGNATURE OF ASST. CHIEF OF CHILD		529. SIGNATURE OF CHIEF OF YOUTH		530. SIGNATURE OF DEPUTY CHIEF OF YOUTH		531. SIGNATURE OF ASST. CHIEF OF YOUTH		532. SIGNATURE OF CHIEF OF ELDERLY		533. SIGNATURE OF DEPUTY CHIEF OF ELDERLY		534. SIGNATURE OF ASST. CHIEF OF ELDERLY		535. SIGNATURE OF CHIEF OF YOUNG		536. SIGNATURE OF DEPUTY CHIEF OF YOUNG		537. SIGNATURE OF ASST. CHIEF OF YOUNG		538. SIGNATURE OF CHIEF OF OLD		539. SIGNATURE OF DEPUTY CHIEF OF OLD		540. SIGNATURE OF ASST. CHIEF OF OLD		541. SIGNATURE OF CHIEF OF INFANT		542. SIGNATURE OF DEPUTY CHIEF OF INFANT		543. SIGNATURE OF ASST. CHIEF OF INFANT		544. SIGNATURE OF CHIEF OF ADULT		545. SIGNATURE OF DEPUTY CHIEF OF ADULT		546. SIGNATURE OF ASST. CHIEF OF ADULT		547. SIGNATURE OF CHIEF OF CHILD		548. SIGN	
---------------------	--	--------	--	--------	--	---------	--	------------------	--	------------------	--	-------------------	--	-------------------	--	--------------------	--	---------------------------	--	--------------------------	--	--------------------------	--	-----------------------	--	------------------------	--	------------------------	--	--------------------------	--	---------------------------------	--	----------------------------	--	-------------------------	--	---------------------------	--	-----------------------------	--	----------------------------------	--	-----------------------------------------	--	-------------------------------	--	--------------------------	--	----------------------------	--	----------------------------	--	----------------------------------	--	-------------------------------	--	--------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	-------------------------------------	--	--------------------------------------------	--	-------------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	--------------------------------------	--	---------------------------------------------	--	--------------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	-------------------------------	--	--------------------------------------	--	-------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	--------------------------------------	--	---------------------------------------------	--	--------------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	-------------------------------------	--	--------------------------------------------	--	-------------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	-------------------------------------	--	--------------------------------------------	--	-------------------------------------------	--	---------------------------------------	--	----------------------------------------------	--	---------------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	--------------------------------------	--	---------------------------------------------	--	--------------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	---------------------------------	--	----------------------------------------	--	---------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	------------------------------------	--	-------------------------------------------	--	------------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	------------------------------------------	--	-----------------------------------------	--	----------------------------------	--	-----------------------------------------	--	----------------------------------------	--	----------------------------------	--	-----------	--

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5042 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65085

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 704 Oak Hill Ave.				d. STREET ADDRESS 704 Oak Hill Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLMOUTH Middle SALOME Last REININGER				4. DATE OF DEATH Month April Day 21 Year 19 60			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 19, 1909		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting clerk		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Factory		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Witmer, Sr.				14. MOTHER'S MAIDEN NAME Ethel May Draper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-1074		17. INFORMANT Address Edward F. Reininger Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330x massive subarachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) due to vascular anomaly DUE TO (c) 10 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Edward W. Ditto , M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Edward W. Ditto III, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/23/1960		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home R. Franklin Rouzer				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE APR 25 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

HAWAIIAN STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED'S NAME [Name]		SEX [Male/Female]		AGE [Age]		DATE OF BIRTH [Date]		PLACE OF BIRTH [Place]	
DECEASED'S RESIDENCE [Address]		DECEASED'S OCCUPATION [Occupation]		DECEASED'S MARITAL STATUS [Single/Married/Widowed/Divorced]		DECEASED'S RACE [Race]		DECEASED'S RELIGION [Religion]	
DECEASED'S SOCIAL SECURITY NUMBER [SSN]		DECEASED'S HUSBAND'S NAME [Husband's Name]		DECEASED'S WIFE'S NAME [Wife's Name]		DECEASED'S FATHER'S NAME [Father's Name]		DECEASED'S MOTHER'S NAME [Mother's Name]	
DECEASED'S DATE OF DEATH [Date]		DECEASED'S TIME OF DEATH [Time]		DECEASED'S PLACE OF DEATH [Place]		DECEASED'S CAUSE OF DEATH [Cause]		DECEASED'S MANNER OF DEATH [Manner]	
DECEASED'S MEDICAL HISTORY [History]		DECEASED'S PRESENT ILLNESS [Illness]		DECEASED'S TREATMENT [Treatment]		DECEASED'S PROGNOSIS [Prognosis]		DECEASED'S FINAL DIAGNOSIS [Diagnosis]	
DECEASED'S SIGNATURE [Signature]		DECEASED'S ADDRESS [Address]		DECEASED'S PHONE NUMBER [Phone]		DECEASED'S MAILING ADDRESS [Mailing Address]		DECEASED'S NEXT OF KIN [Next of Kin]	
DECEASED'S EMPLOYER'S NAME [Employer]		DECEASED'S EMPLOYER'S ADDRESS [Employer Address]		DECEASED'S EMPLOYER'S PHONE NUMBER [Employer Phone]		DECEASED'S EMPLOYER'S MAILING ADDRESS [Employer Mailing Address]		DECEASED'S EMPLOYER'S NEXT OF KIN [Employer Next of Kin]	
DECEASED'S SIGNATURE [Signature]		DECEASED'S ADDRESS [Address]		DECEASED'S PHONE NUMBER [Phone]		DECEASED'S MAILING ADDRESS [Mailing Address]		DECEASED'S NEXT OF KIN [Next of Kin]	



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5043

302

65086

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				d. STREET ADDRESS Downsville			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANNA Middle ELEANOR Last ROHRER				4. DATE OF DEATH Month April Day 15 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 24 1886	
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 15 Hours 19		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
11. BIRTHPLACE (State or foreign country) near Hagerstown Wash Co Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel Hollyday				14. MOTHER'S MAIDEN NAME Alice Talbert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Alice Downey Williamsport R # 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Atherosclerosis & Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus.				INTERVAL BETWEEN ONSET AND DEATH Instant. 10 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1948 to April 10, 1960 , that (I) (we) last saw the deceased alive on April 12, 1960 , and that death occurred at 5 P.M. from the causes and on the date stated above.							
22a. SIGNATURE B B Kneisley				22b. DATE April 10, 1960			
22c. PHYSICIAN'S NAME (Type) B B. KNEISLEY				22d. ADDRESS 148 W. Washington St. Hagerstown Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/18/60		23c. NAME OF CEMETERY OR CREMATORY Mt View Cemetery		23d. LOCATION (City, town, or county) (State) Sharpsburg Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				25. REGISTRAR'S SIGNATURE Arthur S. Kneisley			

Andrew K. Coffman Hagerstown Md.

DATE **APR 20 '60**

10000

CERTIFICATE OF DEATH

10000

NAME OF DECEASED

NAME OF DECEASED

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

AGE AT DEATH

SEX OF DECEASED

SEX OF DECEASED

PLACE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

PLACE OF BIRTH

CERTIFICATE OF DEATH

65087
Reg. Dist. No.

5118

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pa. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Cascade		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro	
c. LENGTH OF STAY IN TB 6 Days		d. STREET ADDRESS 415 S. Potomac St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hawn Conv. Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruth Middle Viola Last Rossman		4. DATE OF DEATH Month April Day 15, Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/30/1900
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Venton, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Belles		14. MOTHER'S MAIDEN NAME Ruth Hummel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Walter F. Rossman, 415 S. Pot. St., Waynesboro Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4344 Cardiac Decomposition DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 April, 1960, to 15 April, 1960, that I last saw the deceased alive on 14 April, 1960, and that death occurred at 3:15 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Robert A. Kiefer M.D. Blue Ridge Summit, Pa. 15 April 60 PHYSICIAN'S NAME (Type) Robert A. Kiefer Blue Ridge Summit Pa.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/60	
22c. NAME OF CEMETERY OR CREMATORY Memorial Shrine		22d. LOCATION (City, town, or county) (State) Franklin Township, Luzerne Co. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter F. Rossman, Waynesboro Pa.		24a. REC'D BY REGISTRAR DATE APR 18 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

434.4

4.4

CERTIFICATE OF DEATH

Reg. Dist. No.

65088

5044

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Estella Middle Eliza Last Roulette		4. DATE OF DEATH Month April Day 21 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 4 Days 14	11. IF UNDER 24 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John D. Rensburg		14. MOTHER'S MAIDEN NAME Emma Hagerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219 36 2603	
17. INFORMANT Mr. Paul Roulette Sharpsburg Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus & infarction 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Postoperative emboli from deep pelvic veins 1 week DUE TO (c) Gastrectomy for bleeding stomach ulcer 2 weeks		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe paralytic ileus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1960 to April 21, 1960 , that I last saw the deceased alive on April 20, 1960 , and that death occurred at 2:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter H. Shealy		ADDRESS (Street, city or town, state) Sharpsburg, Md.	
PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.		DATE SIGNED 4/22/60	
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial	22b. DATE THEREOF April 23-60	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d. LOCATION (City, town, or county) (State) Sharpsburg Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport Maryland		24a. REC'D BY REGISTRAR DATE APR 25 60	24b. REGISTRAR'S SIGNATURE Charles S. Vane

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1900

CERTIFICATE OF DEATH

1901

Washington

District of Columbia

City of Washington

Married

Single

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

5045

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 395 Key Circle		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle Catherine Last Shannon		4. DATE OF DEATH Month April Day 6 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1909
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) looper		10b. KIND OF BUSINESS OR INDUSTRY knitting mill	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George H. Wellinger		14. MOTHER'S MAIDEN NAME Sarah Manious	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-09-4216	
17. INFORMANT James G. Shannon, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rt. Breast with generalized metastasis DUE TO (b) Melanoma DUE TO (c) 170X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1954 to 6 Apr 1960 , and that I last saw the deceased alive on 6 Apr 1960 , and that death occurred at 1245 PM , from the causes and on the date stated above.		ADDRESS (Specify city or town, state) 2301 Poloma St Hagerstown	
ACTUAL SIGNATURE F. F. Lusby		DATE SIGNED 7 Apr 61	
PHYSICIAN'S NAME (Type) F. F. Lusby			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-9-60	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR APR 11 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05963

CERTIFICATE OF DEATH

501

Place

No.

Washington

Register

Life

Register

355 Ave. Circle

355 Ave. Circle

April 6, 1933

Shannon

Georgina

Shannon

March 3, 1933

March 3, 1933

Register, Md.

Register, Md.

Register

John Shannon

George H. Shannon

James G. Shannon, Register, Md.

To

Register

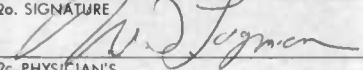
James H. Shannon, Register, Md.

James H. Shannon, Register, Md.

James H. Shannon, Register, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
5046
65090
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 76 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 805 Salem Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle EDGAR Last SINN				4. DATE OF DEATH Month April Day 14 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1880	
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Maker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Harrisburg, Penn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John H. Sinn				14. MOTHER'S MAIDEN NAME Ida Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 214-28-6156		17. INFORMANT Rex Sinn Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Perforated Diverticulum of sigmoid DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease; Carcinoma of sigmoid							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown				20g. (County) Maryland		20h. (State) Maryland	
21. I certify that (I) (the physician) attended the deceased from April 11, 1960 to April 14, 1960 that (I) see last saw the deceased alive on April 14, 1960 , and that death occurred at 8:40 P.M. from the causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE April 14, 1960			
22c. PHYSICIAN'S NAME (Type) W. T. Layman, M.D.				22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/18/1960		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
23d. LOCATION (City, town, or county) Hagerstown				23e. (State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home R. Franklin Keyser				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE APR 18 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna							

~~SECRET~~

5787

1

SECRET

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05091

Reg. Dist. No.

5119

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CLEAR SPRING c. LENGTH OF STAY IN 1b 38 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MUMMERT ROAD				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD. b. COUNTY WASH. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CLEAR SPRING d. STREET ADDRESS MUMMERT ROAD e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle BLAINE Last SITES				4. DATE OF DEATH Month 4 Day 14 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 13, 1889	
9. AGE (In years at birthday) 70 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR				10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) PENNA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE F. SITES				14. MOTHER'S MAIDEN NAME ALBERTA K. STULTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-30-9227A		17. INFORMANT MRS. ELIZABETH SITES Address CLEAR SPRING, RT 2, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.00 Entered obstructed Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (b) 6 yrs [a], stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE A. S. W. [Signature]				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. E. W. [Signature]				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/16/60		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL		22d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. CLARK ADDRESS CLEAR SPRING, MD.				24a. REC'D BY REGISTRAR APR 19 '60		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1954

1
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
5043
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

65092

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>BOONSBORO MD. R. 2</u>			
3. NAME OF DECEASED (Type or print) <u>ELLA M. SMITH</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 26 - 1902</u>		9. AGE (In years lost birthday) <u>57</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>24</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WEAVER - MARYLAND RIBBON CO.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CLEARSPRING WASH. CO. MD. U.S.A.</u>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>WILLIAM YOST</u>			
14. MOTHER'S MAIDEN NAME <u>HATTIE YOST</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>220-18-3034</u>				17. INFORMANT <u>MRS. HELEN MASER BOONSBORO MD. R. 2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>633X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pan. hysterectomy</u> DUE TO (c) <u>Thrombo-phlebitis femoral & pelvic veins</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5-6 days</u> <u>9 days</u> <u>5-6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 17, 1960</u> , to <u>Apr. 20, 1960</u> , that (I) (we) last saw the deceased alive on <u>Apr. 19, 1960</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>R. S. Stauffer</u>				22b. DATE SIGNED <u>Apr. 22, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>R. S. STAUFFER</u>				22d. ADDRESS <u>Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APR. 23, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MT. LENA WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Vlast</u>				ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR <u>APR 25 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							

88930

CENTRAL BUREAU OF DEATH

2011

464

[Faint, mostly illegible text, possibly a form or report, with some handwritten notes.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5091

05093

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO c. LENGTH OF STAY IN lb 4 WEEKS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REEDER NURSING HOME		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LOCUST GROVE, RURAL d. STREET ADDRESS 1 ROHRERSVILLE MD. R.1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GERTRUDE EDNA SMITH		4. DATE OF DEATH Month Day Year APRIL - 3 - 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY - 29 - 1877
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 8 Days 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) LOCUST GROVE WASH. CO. MD. U.S.A		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME ALBERT SMITH		14. MOTHER'S MAIDEN NAME SARAH GRIMM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address MRS. AXEL STEEL ROHRERSVILLE MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED ARTEROSCLEROSIS 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGESTIVE HEART FAILURE DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 year -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PURULENT CISTITIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 6, 1959 to April 3, 1960 , that (I) (we) last saw the deceased alive on 4-2-1960 , and that death occurred at 2:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Joseph Secundari		22b. DATE SIGNED April 4, 1960	
22c. PHYSICIAN'S NAME (Type) Joseph Secundari, M. D.		22d. ADDRESS 21 North Main St. Boonsboro, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 6 - 1960	
23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY		23d. LOCATION (City, town, or county) (State) LOCUST GROVE WASH. CO. MD	
24. FUNERAL DIRECTOR'S SIGNATURE John A. East		25. REC'D BY REGISTRAR APR 7 '60	
ADDRESS BOONSBORO MD		25b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

CENTRAL OF DEATH

1901

1901

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15094
Reg. Dist. No.

5120

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHARPSBURG</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>BEAVER CREEK - RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>BEAVER CREEK - RURAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ALONG ROUTE 34</u>				d. STREET ADDRESS <u>HAGERSTOWN MD. R.I.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND C. CLEVELAND SMITH</u>				4. DATE OF DEATH Month Day Year <u>APRIL - 17 - 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 21 - 1933</u>	
9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months Days <u>1</u> <u>26</u>		IF UNDER 24 HRS. Hours Min. <u>1</u> <u>26</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER SOUTHERN PACKING COMPANY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HAGERSTOWN WASH. CO. MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>							
13. FATHER'S NAME <u>RAYMOND C. SMITH SR</u>				14. MOTHER'S MAIDEN NAME <u>ALICE WEAVER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>220-28-8115</u>		17. INFORMANT Address <u>MRS. SHIRLEY SMITH. HAGERSTOWN MD. R.I.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO <u>Fracture Cervical Vertebrae</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fracture Ribs, Left & Right</u> DUE TO (c) <u>Compound Fracture Rt. Humerus & Radius</u> INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Speeding car left road crashing into tree.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Speeding car left road crashing into tree.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>9:47</u> p. m. <u>4-17-1960</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State R # 34</u>		20f. (City or town) (County) (State) <u>Sharpsburg, Wash. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>S. E. W. Ditto, Jr.</u>		EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-19-60</u>	
				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 22, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bass</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 22 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5048
CERTIFICATE OF DEATH

15095

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>3 WEEKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BENJAMIN FRANKLIN SNYDER</u>		4. DATE OF DEATH Month Day Year <u>APRIL - 15 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 2 - 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED RAILWAY MAIL CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WILLIAMSPORT MD</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>SIMON P. SNYDER</u>		14. MOTHER'S MAIDEN NAME <u>MARY VIRGINIA LEEFIRE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>GEHR W. SNYDER</u>		Address <u>SMITHSBURG MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.1</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last, (b) <u>DUE TO</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-29-60</u> 19 <u>60</u> to <u>4-15-60</u> 19 <u>60</u> , that (I) (we) lost the deceased alive on <u>4-15-60</u> 19 <u>60</u> , and that death occurred at <u>4:50 P</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles F. Hess</u>		22b. DATE SIGNED <u>4-16-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M. D.</u>		22d. ADDRESS <u>Smithsburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 18-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SMITHSBURG CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>SMITHSBURG MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. East</u>		25a. REC'D BY REGISTRAR <u>Boonsboro Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles F. Hess</u>		DATE <u>APR 22 '60</u>	

15092

CERTIFICATE OF DEATH

15092

1

1

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

081

MEDICAL CERTIFICATION



28

65096

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 1302 Oak Hill Ave.			
3. NAME OF DECEASED (Type or print) HARRY First EDGAR Middle SNYDER Last				4. DATE OF DEATH April Month 16 Day 19 Year 60			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1891		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Boonsboro, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Martih Snyder				14. MOTHER'S MAIDEN NAME Ella Hildebrahd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.I 212-38-0001		17. INFORMANT Mrs. Vera Snyder Address Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) Myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-4-1960 to 4-16-1960 that (I) (we) last saw the deceased alive on 4-16-1960 , and that death occurred at 6:45 PM the causes and on the date stated above.							
22a. SIGNATURE John H. Hornbaker				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.				22d. ADDRESS 154 W. Washington St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/19/1960		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City, town, or county) (State) Boonsboro Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home				25a. REC'D BY REGISTRAR DATE APR 21 '60		25b. REGISTRAR'S SIGNATURE Clinton S. Evans	

05908

CERTIFICATE OF DEATH

24012

Blank certificate form with horizontal lines for text entry.

CERTIFICATE OF DEATH

2020

1. Name of Deceased		2. Sex		3. Race	
4. Date of Birth		5. Date of Death		6. Place of Birth	
7. Usual Residence		8. Cause of Death		9. Manner of Death	
10. Signature of Physician		11. Signature of Registrar		12. Signature of Informant	
13. Date of Entry		14. Place of Entry		15. Signature of Informant	
16. Signature of Informant		17. Signature of Informant		18. Signature of Informant	
19. Signature of Informant		20. Signature of Informant		21. Signature of Informant	
22. Signature of Informant		23. Signature of Informant		24. Signature of Informant	
25. Signature of Informant		26. Signature of Informant		27. Signature of Informant	
28. Signature of Informant		29. Signature of Informant		30. Signature of Informant	
31. Signature of Informant		32. Signature of Informant		33. Signature of Informant	
34. Signature of Informant		35. Signature of Informant		36. Signature of Informant	
37. Signature of Informant		38. Signature of Informant		39. Signature of Informant	
40. Signature of Informant		41. Signature of Informant		42. Signature of Informant	
43. Signature of Informant		44. Signature of Informant		45. Signature of Informant	
46. Signature of Informant		47. Signature of Informant		48. Signature of Informant	
49. Signature of Informant		50. Signature of Informant		51. Signature of Informant	
52. Signature of Informant		53. Signature of Informant		54. Signature of Informant	
55. Signature of Informant		56. Signature of Informant		57. Signature of Informant	
58. Signature of Informant		59. Signature of Informant		60. Signature of Informant	
61. Signature of Informant		62. Signature of Informant		63. Signature of Informant	
64. Signature of Informant		65. Signature of Informant		66. Signature of Informant	
67. Signature of Informant		68. Signature of Informant		69. Signature of Informant	
70. Signature of Informant		71. Signature of Informant		72. Signature of Informant	
73. Signature of Informant		74. Signature of Informant		75. Signature of Informant	
76. Signature of Informant		77. Signature of Informant		78. Signature of Informant	
79. Signature of Informant		80. Signature of Informant		81. Signature of Informant	
82. Signature of Informant		83. Signature of Informant		84. Signature of Informant	
85. Signature of Informant		86. Signature of Informant		87. Signature of Informant	
88. Signature of Informant		89. Signature of Informant		90. Signature of Informant	
91. Signature of Informant		92. Signature of Informant		93. Signature of Informant	
94. Signature of Informant		95. Signature of Informant		96. Signature of Informant	
97. Signature of Informant		98. Signature of Informant		99. Signature of Informant	
100. Signature of Informant		101. Signature of Informant		102. Signature of Informant	

5051

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Elizabeth Spielman		4. DATE OF DEATH April 23 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1882
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel C. Spielman		14. MOTHER'S MAIDEN NAME Ida Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. J. E. Roush		Address Cleveland Ohio	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420. Coronary thrombosis DUE TO cerebral thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. general arteriosclerosis DUE TO (b) general arteriosclerosis DUE TO (c) general arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6-8 hr 5 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1, 1960 to Apr 23, 1960 , that I last saw the deceased alive on Apr 21, 1960 , and that death occurred at 8:05 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward W. Ditto III M.D.		ADDRESS (Street, city or town, state) 217 W. Washington St. DATE SIGNED	
PHYSICIAN'S NAME (Type) Edward W. Ditto III		Hagerstown Md.	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF 4-25-60	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR APR 26 60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2051

Washington
Hagerstown
Life

Washington
Hagerstown

Female White
April 14, 1882
Hagerstown Md.
None

Dr. Miller
Mrs. J. E. House - Cleveland Ohio

Edward J. House
Hagerstown Md.

Robert F. Munton
Hagerstown Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1,5098
Reg. Dist. No. #08

5052

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown D.O.A. 03 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash County Hospital				d. STREET ADDRESS 631 George St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALTON LEE STEWART Sr				4. DATE OF DEATH Month Day Year April 17 1960 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 19 1928	
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronics		10b. KIND OF BUSINESS OR INDUSTRY Air Craft		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Stewart				14. MOTHER'S MAIDEN NAME Zella Shenkleton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-24-6832		17. INFORMANT Address Mrs Anna B. Stewart 631 George St Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull DUE TO Crushed Chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture Lumbar Spine DUE TO (c) Fracture Femur, rt. & lt.				INTERVAL BETWEEN ONSET AND DEATH Instant			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Speeding car left road crashing into tree.					
20c. TIME OF INJURY Month, Day, Year Hour 4-17-60 7:41 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State D-4-34		20f. (City or town) (County) (State) Sharpsburg Wash. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				DATE SIGNED 4/19/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/20/60		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR DATE 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED JAMES B. BROWN</p>		<p>AGE 45</p>		<p>SEX Male</p>		<p>RACE White</p>	
<p>DATE OF DEATH August 10, 1923</p>		<p>TIME OF DEATH 10:30 A.M.</p>		<p>PLACE OF DEATH Home</p>		<p>CITY Boston</p>	
<p>RESIDENCE 123 North Street</p>		<p>STREET North Street</p>		<p>CITY Boston</p>		<p>STATE Massachusetts</p>	
<p>CAUSE OF DEATH Heart Disease</p>		<p>MANNER OF DEATH Natural</p>		<p>EDUCATION High School</p>		<p>OCCUPATION Clerk</p>	
<p>PREVIOUS ILLNESS None</p>		<p>PREVIOUS SURGERY None</p>		<p>PREVIOUS TRAUMA None</p>		<p>PREVIOUS DRUGS None</p>	
<p>TESTIMONY OF PHYSICIAN The deceased was found dead at his home, and no one was present at the time of death.</p>		<p>TESTIMONY OF NEAREST RELATIVE The deceased was found dead at his home, and no one was present at the time of death.</p>		<p>TESTIMONY OF NEAREST RELATIVE The deceased was found dead at his home, and no one was present at the time of death.</p>		<p>TESTIMONY OF NEAREST RELATIVE The deceased was found dead at his home, and no one was present at the time of death.</p>	
<p>SIGNATURE OF PHYSICIAN J. B. Brown</p>		<p>SIGNATURE OF NEAREST RELATIVE J. B. Brown</p>		<p>SIGNATURE OF NEAREST RELATIVE J. B. Brown</p>		<p>SIGNATURE OF NEAREST RELATIVE J. B. Brown</p>	
<p>DATE August 10, 1923</p>		<p>TIME 10:30 A.M.</p>		<p>PLACE Home</p>		<p>CITY Boston</p>	

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5053

Item 7 1116201 4-16-60 et
CERTIFICATE OF DEATH

65100

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b X TILGHMANTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARTIN MANOR REST HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BESSIE Middle N. Last SUMAN				4. DATE OF DEATH Month APRIL - Day 6 - Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JULY-21-1876	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 8 Days 15	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) TILGHMANTON WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSIAH BLOOM				14. MOTHER'S MAIDEN NAME ELEANOR FITCH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MISS M. IRENE BLOOM TILGHMANTON MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rec. Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 1 Day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 4/6/60		20g. (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 4/5/60 to 4/6/60 , that (I) (we) lost saw the deceased alive on 4/6/60 , and that death occurred at 6:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE John H. Baer		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/7/60			
22c. PHYSICIAN'S NAME (Type) John H. Baer M.D.		22d. ADDRESS Boonsboro MD.		22e. DATE 4/7/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL-9-1960	23c. NAME OF CEMETERY OR CREMATORY MAJOR CEMETERY		23d. LOCATION (City, town, or county) (State) NEAR TILGHMANTON MD			
24. FUNERAL DIRECTOR'S SIGNATURE John H. Baer		ADDRESS Boonsboro MD.		25a. REC'D BY REGISTRAR DATE APR 12 '60		25b. REGISTRAR'S SIGNATURE William S. Frank	

090

1

0

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

UNITED STATES

CERTIFICATE OF DEATH

1900

11

11

11

11

11

11

11

11

11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5054

05101

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELSIE Middle MINNIE Last SWINK		4. DATE OF DEATH Month April Day 1 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 4, 1901
9. AGE (In years lost birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Operator		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl N. Boger		14. MOTHER'S MAIDEN NAME Elizabeth Fink	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-10-0096	
17. INFORMANT Mrs. Peter H. Priest		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mon 31 19 60 , to Apr 1 19 60 , that (I) (we) last saw the deceased alive on Apr 1 19 60 , and that death occurred at 5:19 M, from the causes and on the date stated above.			
22a. SIGNATURE John C. Stauffer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/4/1960	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home R. Franklin Boger		25a. REC'D BY REGISTRAR APR 5 '60	
ADDRESS Hagerstown, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

20102

CERTIFICATE OF DEATH

20102



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5055

CERTIFICATE OF DEATH

65102

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MADELINE Middle ELIZABETH Last SWISHER				4. DATE OF DEATH Month April Day 7 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 14, 1915	
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min.		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesclerk				10b. KIND OF BUSINESS OR INDUSTRY Newberry's		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland	
13. FATHER'S NAME Albert Magaha				14. MOTHER'S MAIDEN NAME Grace Hankey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 214-09-8455		17. INFORMANT John A. Swisher Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of cervix - extensive regional DUE TO metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 171X (c) 171X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 171X INTERVAL BETWEEN ONSET AND DEATH 1 yr							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) May 1959 to 7 apr 1960				20g. (County) Washington		20h. (State) Md	
21. I certify that (I) (this hospital) attended the deceased from May 1959 to 7 apr 1960 , that (I) (we) last saw the deceased alive on 7 apr 1960 , and that death occurred at 8:15 AM from the causes and on the date stated above.							
22a. SIGNATURE F F Lusby				22b. DATE SIGNED 8 apr 60		22c. PHYSICIAN'S NAME (Type) F F Lusby	
22d. ADDRESS 2301 Potters Hagerstown Md				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/9/1960		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
23d. LOCATION (City, town, or county) Hagerstown, Maryland				23e. (State) Md			
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home B. Franklin Rouzer				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR APR 11 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Harris				25c. (State) Md			

5005

CERTIFICATE OF DEATH

5005

11



1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5056
65103
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Rx Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Doubs 10X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Gertrude Last Talbott		4. DATE OF DEATH Month 4 Day 29 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 June 1869
9. AGE (In years lost birthday) yrs. 90		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jonathan Talbott	
14. MOTHER'S MAIDEN NAME Sarah Frances Walters		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT 309 N. Frederick Ave., Roy L. Talbott, Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular Pneumonia DUE TO (b) Carcinoma of Pancreas Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular disease, Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 5 days 5 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 9, 1958 to April 29, 1960 that (I) (we) lost saw the deceased alive on April 29, 1960 , and that death occurred at 6:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun		22b. DATE SIGNED April 29, 1960	
22c. PHYSICIAN'S NAME (Type) Young E. Chun		22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-3-60	
23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d. LOCATION (City, town, or county) (State) Beallsville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE MAY 2 '60	
25b. REGISTRAR'S SIGNATURE William S. Kline			

© 2006 The Authors
Journal compilation © 2006 Blackwell Publishing Ltd

1967-1968

212

Case

22-15-2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5057
CERTIFICATE OF DEATH65104
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				d. STREET ADDRESS 927 Hamilton Blvd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM AUGUSTUS TOBIAS Jr				4. DATE OF DEATH Month Day Year April 16 1960 19			
5. SEX Male		6. COLOR OR RACE white		7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 28 1878	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Senior Clerk				10b. KIND OF BUSINESS OR INDUSTRY Draft Board		11. BIRTHPLACE (State or foreign country) Reading Berks Co Pa	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William A. Tobias Sr				14. MOTHER'S MAIDEN NAME Amanda			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. Spanish 314-09-1459		17. INFORMANT Address Mrs Daisy Tobias 927 Hamilton Blvd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach DUE TO 181.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH 6 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 19 59 to 4/16/60 , that (I) (we) last saw the deceased alive on Apr 16 1960 , and that death occurred at 5 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Arthur S. Kline				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 18/60	
22c. PHYSICIAN'S NAME (Type) H. B. Beachler				22d. ADDRESS Hagerstown, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/18/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md				ADDRESS		25a. REC'D BY REGISTRAR APR 20 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

43198

CERTIFICATE OF DEATH

2001

ASSIGNMENT

WILLIAM

DATE

ASSIGNMENT

ASSIGNMENT

WILLIAM

ASSIGNMENT

ASSIGNMENT

ASSIGNMENT

ASSIGNMENT

WILLIAM

ASSIGNMENT

ASSIGNMENT

WILLIAM

ASSIGNMENT

WILLIAM

ASSIGNMENT

ASSIGNMENT

WILLIAM

ASSIGNMENT

WILLIAM

ASSIGNMENT

WILLIAM

ASSIGNMENT

WILLIAM

ASSIGNMENT

ASSIGNMENT

WILLIAM

ASSIGNMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 5053
 CERTIFICATE OF DEATH
 65105
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7½ hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julia Middle Paulding Last Towson		4. DATE OF DEATH Month April Day 11 , Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10b. KIND OF BUSINESS OR INDUSTRY Huntington, L.I., N.Y.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Hiram Paulding		14. MOTHER'S MAIDEN NAME Virginia Mulligan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-34-4195	
17. INFORMANT A. Lee Towson, Jr., Lewiston, .N.Y.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____		INTERVAL BETWEEN ONSET AND DEATH 7½ hrs. 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-2-60 , 19____, to 4-11-60 , 19____, that I last saw the deceased alive on 4-11-60 , 19____, and that death occurred at 9:00 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Smithsburg, Md. 4-12-60			
ACTUAL SIGNATURE Charles F. Hess		M.D. Smithsburg, Md.	
PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-13-60	
22c. NAME OF CEMETERY OR CREMATORY Smithsburg Mausoleum		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR DATE APR 14 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

420.

1
5
M
081
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

65106

5059

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b -	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 1 Boonesboro d. STREET ADDRESS Route 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Vannie First Veon (John) Middle Virts Last		4. DATE OF DEATH 4 Month 9 Day 19 Year 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-1906
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furloughed Faiechild		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Co	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John R. Virts		14. MOTHER'S MAIDEN NAME SCHILLING Ida E. Schilling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Informant Mrs. Ethel Virts, Boonesboro, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Essential hypertension DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 hour 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 9, 1960 to April 9, 1960 , that I last saw the deceased alive on April 2, 1960 , and that death occurred at 6:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 21 North Main St. Boonesboro, Maryland DATE SIGNED 4/11/60 ACTUAL SIGNATURE Joseph Secondari M.D. PHYSICIAN'S NAME (Type) Joseph Secondari, M. D. Boonesboro, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-12-1960	
22c. NAME OF CEMETERY OR CREMATORY Park Heights		22d. LOCATION (City, town, or county) (State) Brunswick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. H. Fute		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR DATE MAY 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

103106

CERTIFICATE OF DEATH

2022

Registration

Medical

Signature

Registration

Signature

Registration

-

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5060
CERTIFICATE OF DEATH
302 65107

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 5 Mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) 926 Oak Hill Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SCOTT Middle RAYMOND Last WAGNER				4. DATE OF DEATH Month April Day 5 Year 1960			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 16 1874	
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman				10b. KIND OF BUSINESS OR INDUSTRY Retired			
11. BIRTHPLACE (State or foreign country) Ickesburg Perry Co Pa.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John W. Wagner				14. MOTHER'S MAIDEN NAME Sarah Eliz Eby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W.# 1 217-32-6046			
17. INFORMANT Mrs Lorene Fox Wagner				Address 926 Oak Hill Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vasc. Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) Hagerstown Md. INTERVAL BETWEEN ONSET AND DEATH 6 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aneurysm of Abdominal Aorta - 5 mo.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Mar 1 19 60 , to Apr 5 19 60 , that (I) (we) last saw the deceased alive on 4-5 19 60 , and that death occurred at 7 AM , from the causes and on the date stated above.							
22a. SIGNATURE Robert P. Conrad, MD				22b. DATE SIGNED 4-5-60			
22c. PHYSICIAN'S NAME (Type) Robert P. Conrad				22d. ADDRESS 137 W. Washington Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/8/60			
23c. NAME OF CEMETERY OR CREMATORY Hummelstown Cemetery				23d. LOCATION (City, town, or county) (State) Hummelstown Dauphin Co Pa			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				25a. REC'D BY REGISTRAR APR 11 '60			
ADDRESS Hagerstown Md.				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

65107

CERTIFICATE OF DEATH

6009

Washington

Washington

1907

1907

April 5 1907

Raymond

Raymond

1874

Raymond

Raymond

Raymond

Raymond

Raymond

Raymond

Raymond

Raymond

Raymond

Raymond

Raymond

Raymond

Raymond

Raymond

Raymond

5061

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

65108

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>Hazel</u> Last <u>Walls</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 11, 1916</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Months <u>4</u> Days <u>4</u> Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewing Machine Operator Sewing Factory</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Jacob Bros.</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.B.</u>			
13. FATHER'S NAME <u>Millard F. Bishop</u>				14. MOTHER'S MAIDEN NAME <u>Anna B. Munson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Ramona Creek Hancock, Md.</u>			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Anterioschrotic (coronary) Heart Disease</u> DUE TO (b) <u>Multiple pulmonary emboli</u> DUE TO (c) <u>1 month?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between ONSET AND DEATH about 2 years - 1 month?</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3-29, 1960</u> , to <u>4-4, 1960</u> , that (I) (we) last saw the deceased alive on <u>4-4, 1960</u> , and that death occurred at <u>7:50 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John H. Hornbaker</u>				22b. DATE SIGNED <u>APR 12 '60</u>			
22c. PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>				22d. ADDRESS <u>154 West Washington St., Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4-8-60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Washington Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Stone Hancock Md</u>				25a. REC'D BY REGISTRAR DATE <u>APR 12 '60</u>			
				25b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>			

081

1

2

1

1

I, the undersigned, being a duly qualified Medical Officer of Health for the District of _____, do hereby certify that _____
 was born on the _____ day of _____, 19____, at _____, in the County of _____, State of _____.
 He/She died on the _____ day of _____, 19____, at _____, in the County of _____, State of _____.
 The cause of death was _____
 as certified by the attending physician, _____, M.D., who has signed the accompanying medical certificate.
 The death was caused by _____
 and was not due to any contagious or infectious disease.
 The death was reported to me by _____, who has signed the accompanying report.
 I hereby certify that the foregoing is true and correct.
 Signed and sworn to before me on the _____ day of _____, 19____.

 Notary Public for the State of _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please see certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5121

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dtn. No.

5109

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ringgold		c. LENGTH OF STAY IN lb 10 Min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) westminster		0627.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Junction				d. STREET ADDRESS W. Md Cpllege		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET CHRISTINE WAPPLER				4. DATE OF DEATH Month Day Year April 2 1960 19			
5. SEX female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 17 1932	
9. AGE (In years last birthday) 27 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Teacher		11. BIRTHPLACE (State or foreign country) Denver Denver Co Colo.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Werner J. Wappler				14. MOTHER'S MAIDEN NAME Ruth F. Francis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ----		17. INFORMANT Address Werner J. Wappler 5685 Minnesota Ave Denver 22 Colo			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 816X DUE TO FRACTURED SKULL FRACTURED RIBS (CHEST CRUSHED) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COUMPOUND FRACTURE LOWER JAW DUE TO (c) FRACTURE OF LEFT WRIST				INTERVAL BETWEEN ONSET AND DEATH 10 MIN.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) RAMED THRU STOP SIGN-STRUCK BY TRACTOR TRAILER			
20c. TIME OF INJURY Month, Day, Year 12:45 p.m. 4-2- 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) JUNC. RT. 64&418		20f. (City or town) (County) (State) LEITERSBURG, WASH. MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE DR. E.W. DITTO, JR.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)				DATE SIGNED 4/2/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/7/60		22c. NAME OF CEMETERY OR CREMATORY Fair Mount Cemetery		22d. LOCATION (City, town, or county) (State) Denver Denver Co Colo	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR DATE APR 5 '60		24b. REGISTRAR'S SIGNATURE John J. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

5062

302 05110

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 23Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1127 Oak Hill Ave				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1127 Oak Hill Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last STANLEY TELFORD WELDER				4. DATE OF DEATH Month Day Year April 21 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 13, 1897	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Sales Mang Hoffman Chevrolet Reading Berks Co Pa				10b. KIND OF BUSINESS OR INDUSTRY USA			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William F. Welder				14. MOTHER'S MAIDEN NAME Elizabeth Hazelhurst			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. W.W#1 214-09-3998		17. INFORMANT Address Mrs Ruth C. Welder, 1127 Oak Hill Ave Hagerstown Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis (General) DUE TO (c) 18 yrs				INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus - 10 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr 21 1960 to Apr 21 1960 , that (I) (we) last saw the deceased alive on Apr 21 1960 and that death occurred at 1127 Oak Hill Ave , from the causes and on the date stated above.							
22a. SIGNATURE J. H. Beachley				22b. DATE SIGNED APR 25 '60			
22c. PHYSICIAN'S NAME (Type) J. H. Beachley				22d. ADDRESS Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/24/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				25a. REC'D BY REGISTRAR APR 25 '60			
ADDRESS Hagerstown, Md				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



2003

CERTIFICATE OF DEATH



1. Name of deceased: STANLEY TIMOTHY
2. Date of birth: 1-11-21
3. Date of death: 1-11-21
4. Place of birth: [illegible]
5. Cause of death: [illegible]
6. Signature of physician: [illegible]
7. Signature of registrar: [illegible]
8. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5063
CERTIFICATE OF DEATH
302
05111

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 4 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 525 Frederick St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DAVID EARL WOLF Sr		4. DATE OF DEATH Month Day Year April 20 1960 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25 1891
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 1 0 0 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Wolf & Son	
11. BIRTHPLACE (State or foreign country) Boonsboro Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Wolf		14. MOTHER'S MAIDEN NAME Laura Martz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 314-09-8133	
17. INFORMANT Mrs Lillian Wolf		Address 525 Frederick St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.		INTERVAL BETWEEN ONSET AND DEATH 1 month. 1 year.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 18, 1960 to Apr. 20, 1960 that (I) (we) last saw the deceased alive on Apr. 20, 1960 , and that death occurred 1:32 P from the causes and on the date stated above.			
22a. SIGNATURE R. A. Bell		22b. DATE SIGNED Apr. 22, 1960.	
22c. PHYSICIAN'S NAME (Type) R. A. Bell, M.D.		22d. ADDRESS Hagerstown, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/23/60	
23c. NAME OF CEMETERY OR CREMATORY rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co MD	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25. REC'D BY REGISTRAR DATE APR 25 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Huns			

10113

CERTIFICATE OF DEATH

5013

Washington
Date of Death
Place of Death
Cause of Death
Age at Death
Sex
Color
Marital Status
Occupation
Education
Religion
Signature of Physician
Signature of Registrar
Date of Registration

1
Name of Deceased
Date of Birth
Place of Birth
Date of Death
Place of Death
Cause of Death
Age at Death
Sex
Color
Marital Status
Occupation
Education
Religion
Signature of Physician
Signature of Registrar
Date of Registration

1
Name of Deceased
Date of Birth
Place of Birth
Date of Death
Place of Death
Cause of Death
Age at Death
Sex
Color
Marital Status
Occupation
Education
Religion
Signature of Physician
Signature of Registrar
Date of Registration

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5064

Reg. Dist. No.

65112

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 40 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BARR First WARREN Middle WOLFE Last		4. DATE OF DEATH APRIL 25 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/12/1903
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY GENL. CONTRACTOR	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WADE WOLFE		14. MOTHER'S MAIDEN NAME EVA WARRENFELTZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-1215	
17. INFORMANT MR. DELPHIN WOLFE		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO <u>Blocky myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (b) <u>general arteriosclerosis & arterio-sclerotic heart Disease</u> DUE TO (c) <u>5 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Edward W. Ditto III, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto III, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/26/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/28/60	
22c. NAME OF CEMETERY OR CREMATORY REFORMED CEM.		22d. LOCATION (City, town, or county) (State) WOLFESVILLE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Hornum, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE APR 29 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

5096 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

45113
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>64 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>24 E. Salisbury Street</u>				d. STREET ADDRESS <u>24 E. Salisbury Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>C.</u> Last <u>Zimmerman</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 18 1895</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Emmett Cullen</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Eva Cushwa</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Sumner Draper T Mathews N. Carolina</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Vascular Disease</u> (c) <u></u> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>10 years</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>N. E. D. Outh Jr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>W. E. W. D. T. O. Jr</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 9-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport, Md.</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR DATE <u>APR 11 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Cullen & K...</u>	

DATE SIGNED

4/7/60

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
JAMES J. JONES		45		M		W		1918		10:30 AM		HOME		BALTIMORE		BALTIMORE		MD	
FATHER'S NAME		MOTHER'S NAME		BIRTH DATE		BIRTH PLACE		EDUCATION		OCCUPATION		MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE STATE		MARRIAGE COUNTY	
JAMES J. JONES		JANE J. JONES		1873		MD		HIGH SCHOOL		LABORER		1900		BALTIMORE		MD		BALTIMORE	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		TOXIC		INFECTIOUS		TRAUMATIC		OTHER		SPECIFIC		GENERAL		LOCAL	
NONE		HEART DISEASE		NATURAL		NO		YES		NO		NO		NO		NO		NO	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
J. J. JONES		M.D.		1918		HOME		BALTIMORE		BALTIMORE		MD		BALTIMORE		BALTIMORE		MD	
SIGNATURE OF NEXT OF KIN		RELATIONSHIP		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
J. J. JONES		WIFE		1918		HOME		BALTIMORE		BALTIMORE		MD		BALTIMORE		BALTIMORE		MD	
SIGNATURE OF BURIAL OFFICIAL		TITLE OF BURIAL OFFICIAL		DATE OF BURIAL		PLACE OF BURIAL		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
J. J. JONES		PASTOR		1918		CHURCH		BALTIMORE		BALTIMORE		MD		BALTIMORE		BALTIMORE		MD	